

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5947

05937

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>1mth12dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>10506 Reisterstown Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Nellie</b>	Middle <b>Packard</b>	Last <b>Adams</b>	4. DATE OF DEATH <b>June 11</b>	Month Day Year <b>19 57</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 28, 1896</b>	9. AGE (In years lost birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstress (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John Packard</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-01-4647</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured heart</b>					
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic infarction					
DUE TO Arteriosclerotic cardiovascular disease with hypertension					
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 24, 1957</b> , to <b>June 11, 1957</b> that I last saw the deceased alive on <b>June 11, 1957</b> , and that death occurred at <b>1:00 AM</b> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>Stella Wachsler, M.D.</b> DATE SIGNED <b>6-11-57</b>					
ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D. SPRING GROVE STATE HOSPITAL					
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b> Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/13/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Methodist Church Cemetery</b>		22d. LOCATION (City, town, or county) <b>Finksburg, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Baets</b>					
ADDRESS <b>17 md.</b>					
24a. REC'D BY REGISTRAR DATE <b>6/13/57</b>					
24b. REGISTRAR'S SIGNATURE <b>A. H. Kennedy</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 13 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5948

## CERTIFICATE OF DEATH

05938  
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 16 <b>39 Days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>810 Homestead Street</b>			
3. NAME OF DECEASED (Type or print) <b>EDWARD</b>		First <b>W.</b>	Middle <b>AMSPACHER</b>	Lost	4. DATE OF DEATH <b>June 14</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/1/15</b>	9. AGE (In years day/birthday) <b>42</b> yrs.	10. IF UNDER 1 YEAR Months <b>14</b>	11. IF UNDER 24 HRS. Days <b>19</b>	12. Year Hours <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Veterans Admin.</b>		11. BIRTHPLACE (State or foreign country) <b>Glen Rock, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward W. Amspacher, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Nelson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>577-22-3621</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ACUTE PULMONARY EDEMA				INTERVAL BETWEEN ONSET AND DEATH HOURS	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) MYOCARDIAL INFARCTION				3 WEEKS	
DUE TO		DUE TO				DUE TO	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that attended the deceased from May 6, 1957, to June 14, 1957.		and that death occurred at 4:15 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Chien Wet Lan</i>		ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED <b>6/14/57</b>					
PHYSICIAN'S NAME (Type) <b>CHIEN WET LAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Meadowridge Memorial</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook Blight, Inc.</i>		ADDRESS <b>6009 Harford Rd., Balt. 14, Md.</b>		24a. REC'D BY REGISTRAR <b>6/18/57</b>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Gandy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CONFIDENTIAL - SECURITY INFORMATION OF THE STATE DEPARTMENT

CONFIDENTIAL - SECURITY INFORMATION OF THE STATE DEPARTMENT

BUREAU U. S.  
RECEIVED  
JUN 19 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5949

## CERTIFICATE OF DEATH

05939  
80

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE				
<i>Baltimore Maryland</i>		<i>Md Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b <i>Stoneleigh years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Newtown Baltimore</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Luke's</i>	d. STREET ADDRESS <i>610 Fatherly St. Rd.</i>	e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>James Edward Atwell</i>	First <i>J</i>	Middle <i>James</i>	Last <i>Atwell</i>			
4. DATE OF DEATH <i>June 24 1957</i>	Month <i>June</i>	Day <i>24</i>	Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 18 1886</i>			
9. AGE (In years last birthday) <i>71 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>George G. Atwell</i>	14. MOTHER'S MAIDEN NAME <i>Walt Spencer</i>	Address <i>113 W. Lutherville Baltimore Md</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>4500</i>	17. INFORMANT <i>None</i>	18. INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i>						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4500</i>						
(b) DUE TO <i>Cardiac Failure</i>		24 hrs				
(c) <i>arteriosclerosis, severe</i>		10 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>Lutherville, Md</i>	(County) <i>None</i>	(State) <i>None</i>
21. I certify that I attended the deceased from <i>March 5, 1957</i> to <i>June 24, 1957</i> , that I last saw the deceased alive on <i>June 22, 1957</i> , and that death occurred at <i>None</i> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Lutherville, Md</i>		DATE SIGNED <i>6/24/57</i>				
ACTUAL SIGNATURE <i>George Gilmore M.D.</i>						
PHYSICIAN'S NAME (Type) <i>G.T. GILMORE, MD</i>		LUTHERVILLE, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>July 26/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Steinbach Mortuary - 10807 North Baltimore</i>		ADDRESS <i>10807 North Baltimore</i>		24d. REG'D BY REGISTRAR DATE <i>JUN 20 1957</i>	24e. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OPTIONAL FORM NO. 10  
MAY 1962 EDITION  
GSA GEN. REG. NO. 27

BUREAU V. 8

JUN 26 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05940

5950

## CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>		b. COUNTY <b>PRINCE GEORGE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. LENGTH OF STAY IN 1b <b>1 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>		d. STREET ADDRESS <b>16X1-2</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	<b>ROLAND</b>	Middle <b>MURPHY</b>	Last <b>BADEN</b>	4. DATE OF DEATH	<b>JUNE</b>	Month <b>1</b>	Day <b>Year</b> <b>1957</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-4-01</b>	9. AGE (In years lost birthday) <b>56 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Robacco FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>THOMAS W. BADEN</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Hyde</b>		Address <b>Hospital Records, Mt. Wilson State Hospital</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MENINGITIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> <u>lying cause lost.</u> <b>010X</b> (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>60-days</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY TUBERCULOSIS, AGRANULOCYTOSIS</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>White</b>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baden</b>		20f. (City or town) (County) (State) <b>Mt. Wilson, Maryland</b>		
21. I certify that I attended the deceased from <b>9-4-56</b> to <b>6-1-57</b> , that I last saw the deceased alive on <b>6-1-57</b> , and that death occurred at <b>11:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b>								
ACTUAL SIGNATURE <b>William Newcomer</b>		DATE SIGNED <b>6/1/57</b>						
PHYSICIAN'S NAME (Type) <b>WILLIAM NEWCOMER, M. D., SUPERINTENDENT</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baden</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Funeral Home-Marlboro, Md.</b>		ADDRESS <b>Upper</b>		24a. REC'D BY REGISTRAR <b>JUN 6 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Southern Maryland</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILSON STATE GOVERNMENT OF TEXAS

CERTIFICATE OF DEATH

✓ 6

WHITE MINING

BIRMINGHAM THERAPEUTICAL ASSOCIATION

BUREAU V. 5

JUN 6 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18  
5951 CERTIFICATE OF DEATH

05941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b>		b. COUNTY <b>BALTO,</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROSEDALE (6)</b>		c. LENGTH OF STAY IN lb <b>10 MO.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 ROSEDALE (6)</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3305 PHILA. RD.</b>		d. STREET ADDRESS <b>18505 PHILA. RD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>LILLIAN GETTMAN BAERWALD</b>		First	Middle	Last	4. DATE OF DEATH <b>6 - 3 - 1957</b>	Month	Day	Year
5. SEX <b>WOM.</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 6, 1885</b>	9. AGE (in years from last birthday) <b>72</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>JOHN GETTMAN</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Rudolph Baerwald</b>		Address <b>as above</b>		
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary Occlusion</b>		DUE TO (b) <b>At. Scherzer Heart Service</b>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. n. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>520 BALTO. RD.</b>		20f. (City or town) <b>BALTO.</b>	(County)	(State)
21. I certify that I attended the deceased from <b>Jun 1, 1957</b> to <b>June 3, 1957</b> , that I last saw the deceased alive on <b>June 3, 1957</b> , and that death occurred at <b>10 M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>BALTO., MD.</b>						DATE SIGNED <b>6-6-57</b>
ACTUAL SIGNATURE <b>Roger Winsor</b>								
PHYSICIAN'S NAME (Type) <b>Roger Winsor, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-6-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>OAK LAWN</b>		22d. LOCATION (City, town, or county) <b>BALTO., MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walt Joseph Bradley, Maryland, MD.</b>		ADDRESS <b>—</b>						
		24a. REC'D BY REGISTRAR DATE <b>JUN 5 1957</b>						24b. REGISTRAR'S SIGNATURE <b>Edith Shuley</b>

AMERICAN STATE CIVIL SERVICE COMMISSION - WASHINGTON, D.C.

CERTIFICATE OF DEATH

BUREAU V. S

JUN 5 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5952

## CERTIFICATE OF DEATH

05942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYNSVILLE</b>		c. LENGTH OF STAY IN 1b <b>9 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
3. NAME OF DECEASED (Type or print) <b>EMMA</b>		First <b>IRENE</b>	Middle <b>BAKER</b>
4. DATE OF DEATH <b>JUNE 22 1957</b>		Last <b>BAKER</b>	Month Day Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-26-1872</b>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>WALTER C. FOSTER</b>		14. MOTHER'S MAIDEN NAME <b>EMMA J. COLLINS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Frank L. Smith Jr. - Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  DUE TO  (b)  DUE TO  (c)		INTERVAL BETWEEN ONSET AND DEATH  <i>Hypostatic pneumonia</i>  <i>Hypertensive arteriosclerotic cardiovascular disease</i> over 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <i>Cancer of breast with metastases - over 3 yrs</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-14</b> , 1957, to <b>6-22</b> , 1957, that I last saw the deceased alive on <b>6-22</b> , 1957, and that death occurred at <b>3:58 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)  <b>Cockeysville, Md.</b> DATE SIGNED <b>6/25/57</b>	
ACTUAL SIGNATURE  <i>Walter C. Foster</i>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-25-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Baker's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Harford Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE  <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS	
24a. REC'D. BY REGISTRAR DATE <b>JUN 25 57</b>		24b. REGISTRAR'S SIGNATURE  <i>R. L. Beacock</i>	

BUREAU V. S.

JUN 25 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05943

5953

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>56 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>611 Montpelier Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)	First <b>Samuel</b>	Middle <b>LeRoy</b>	Last <b>(NMI)</b>	BANKS	4. DATE OF DEATH	Month <b>June</b>	Day <b>11</b>	Year <b>1957</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1891</b>	9. AGE (In years last birthday) <b>66</b>	IF UNDER 1 YEAR Months <b>6</b>	Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>	10. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Robert Banks</b>				14. MOTHER'S MAIDEN NAME <b>Mary G. Drummond</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>215-10-0184</b>		17. INFORMANT <b>Clin.Rec., Vet Adm. Hosp., Ft. Howard, Md.</b>		Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b>				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>									
IMMEDIATE CAUSE (a) <b>332X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO <b>CEREBRAL THROMBOSIS</b>				UNKNOWN									
DUE TO <b>CEREBRAL THROMBOSIS</b> (c) DUE TO <b>CEREBRAL ATHEROSCLEROSIS</b>				UNKNOWN									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>22-11X</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)					
21. I certify that I attended the deceased from <b>April 16, 1957</b> , to <b>June 11, 1957</b> , and that death occurred at <b>2:25 PM</b> , from the causes and on the date stated above.													
ACTUAL SIGNATURE 	PHYSICIAN'S NAME (Type) <b>ARTHUR G. EDWARDS, M. D.</b>		M.D.		ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Md.</b>		DATE SIGNED <b>6/11/57</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/14/1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	(State)									
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck Funeral Home, 5305 Harford Rd.</b>		ADDRESS <b>Baltimore, Md.</b>	24a. REG'D BY REGISTRAR DATE <b>JUN 13 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Dawson Z</b>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUN 13 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5954

## CERTIFICATE OF DEATH

Reg. Dist. No. 5944

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <b>House in the Pines</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines</b>		e. STREET ADDRESS <b>5922 Charnwood Road</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b>ETHYL</b>	Last <b>BARKMAN</b>
4. DATE OF DEATH	Month <b>June</b>	Day <b>19</b>	Year <b>19 57</b>
S SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>September 28, 1888</b>
			9. AGE (in years last birthday) <b>68 yrs</b>
			10. IF UNDER 1 YEAR Months <b>0</b>
			IF UNDER 24 HRS Days <b>0</b>
			Hours <b>0</b>
			Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Chestertown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles E. Barkman</b>		14. MOTHER'S MAIDEN NAME <b>Lottie R. Wedi</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Mrs. Robt. Mugford - 106 W. University Pkwy</b>	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause first <b>Adreno. Tumor</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Arteritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
21. I certify that I attended the deceased from <b>June 12, 1956</b> , to <b>June 19, 1957</b> , that I last saw the deceased alive on <b>June 18, 1957</b> , and that death occurred at <b>12:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4123 Frederick Ave.</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>James W. Katzenberger</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>Dr. James W. Katzenberger</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ellsworth Armacost</b>		24a. REC'D BY REGISTRAR <b>JUN 26 '57</b>	
		24b. REGISTRAR'S SIGNATURE <b>R. L. Schuck</b>	

BUREAU A. S.

JUN 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5955

## CERTIFICATE OF DEATH

05945

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached from the hospital or attending physician's carbon papers. Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7,					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RIDGEWOOD NURSING HOME				d. STREET ADDRESS 5745 Edmonston Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LOUISE VINYARD		First	Middle	Last	4. DATE OF DEATH 6/12/57	Month	Day Year 19		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890		9. AGE (In years ( <sup>b</sup> birthday) yrs)	10. IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles E. Vinyard				14. MOTHER'S MAIDEN NAME Emma Wagner					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO - - -		17. INFORMANT Mr. Samuel E. Barnes 1172 St. Agnes Lane		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis</i> <i>1979</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>primary source unknown</i> DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>loss of visual function, edema; obesity, C.V.D.</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>12/14</i> , 1956 to <i>6/12</i> , 1957, that I last saw the deceased alive on <i>6/12</i> , 1957, and that death occurred at <i>12:45</i> P.M., from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>5721 Park Boulevard 15, Md</i>	
ACTUAL SIGNATURE <i>Leomial Wilson M.D.</i>								DATE SIGNED <i>6/13/57</i>	
PHYSICIAN'S NAME (Type) <i>DANIEL WILFSON MD.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/57		22c. NAME OF CEMETERY OR CRÉMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) Balto. City		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick A. Cole</i>		ADDRESS 1913 W. Balto. St.		24a. REC'D BY REGISTRAR DATE JUN 17 57		24b. REGISTRAR'S SIGNATURE <i>W. K. Smith</i>			

BUREAU V. S.

JUN 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5956 CERTIFICATE OF DEATH

05946  
30

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

Emma Beaumont

2. DATE  
OF  
DEATH

june 21, 1957

3. PLACE OF DEATH:

A. Baltimore City, Maryland

Catonsville

B. FULL NAME OF HOSPITAL OR INSTITUTION  
Shady Nook Nursing Home  
1002 Rolling Road

(If not in hospital or institution, give street address or location)

c LENGTH OF STAY IN BALTIMORE

Yrs.  
Mos.  
Days

5. SEX

6. COLOR OR RACE

Female

White

7. SINGLE, MARRIED,  
WIDOWED DIVORCED (Specify)

Widowed

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

Housewife

13. FATHER'S NAME

? Naff

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

None

16. SOCIAL SECURITY NO.

None

18.

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

## CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

BRONCHOPNEUMONIA

50 days

(A) DUE TO

## 1/1 ANTECEDENT CAUSES

ARTERIO SCLEROSIS, GEN.

10 yrs.?

(B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(C) .

## CERTIFICATION

491X

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK  NOT WHILE AT WORK 

22. I hereby certify that I attended the deceased from 6/18/1957 to 6/21/1957, that I last saw the deceased alive on 6/21/1957, and that death occurred at 5 P.M., from the causes and on the date stated above.

23A. SIGNATURE

Paul R. ZIEGLER M.D.

23B. ADDRESS

3723 EDMUNDSON AV

23C. DATE SIGNED

6/22/57

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

Burial

24B. DATE

6/24/1957

24C. NAME OF CEMETERY OR CREMATORIUM

Loudon Park

24D. LOCATION (City, town, or county)

Baltimore, Md.

(State)

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

A. H. Heberling

25. FUNERAL DIRECTOR

ADDRESS

Wm. J. Tuckett &amp; Sons - Balt., Md.

RECEIVED  
BUREAU # 8

JUN 25 1962

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05947

## 5957 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 33

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral parlor. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1113. Page 11 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN 1b <b>in transit</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>in Reist. Ambulance on way to Balt.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>			
3. NAME OF DECEASED (Type or print) <b>Edward A. Bell</b>		d. STREET ADDRESS <b>Old Hanover Road</b>			
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH <b>June 26, 1957</b>	Month <b>19</b>	Day <b>19</b>	Year		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1900</b>		
9. AGE (In years last birthday) <b>57</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man at Inn</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>William Bell</b>	14. MOTHER'S MAIDEN NAME <b>Sally</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>213-05-7189</b>	17. INFORMANT <b>Mrs. Thomas Wolfe, Reisterstown, Md.</b>	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO					
(c)					
INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Portal Cirrhosis of Liver - 2 yrs.</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>none</b>			
20c. TIME OF INJURY Hour a. m. p. m. <b>none 19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <b>none</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	20f. (City or town) <b>none</b>	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>D. D. Caples</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>6-28-57</b>
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>	22b. DATE THEREOF <b>June 29, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Park</b>	22d. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>	
VS. A15ME(S) 5M 9/55	22e. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22f. RECORD BY REGISTRAR DATE <b>6/28/57</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>	ADDRESS <b>Reisterstown, Md.</b>		24b. REGISTRAR'S SIGNATURE DATE <b>Mary B. Eline</b>		
				24a. REC'D BY REGISTRAR	

RECEIVED  
BUREAU V. S.

JUL 5 1968

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5958

## CERTIFICATE OF DEATH

0594815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	c. LENGTH OF STAY IN 1b <u>132 Back River Neck Rd.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>132 Back River Neck Rd.</u>		d. STREET ADDRESS <u>132 Back River Neck Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Edward</u>	Middle <u>Anthony</u>	Last <u>BENGIES</u> DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Oct 18-1903</u> AGE (In years from last birthday) <u>53</u> yrs IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHIP-FITTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth-Shipy</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>ANDREW BENGIES</u>		14. MOTHER'S MAIDEN NAME <u>NADOLNY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>CATHERINE BENGIES</u> SAME Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (a) DUE TO (b) <u>Coronary Occlusion</u> Sudden (c) <u>Arteriosclerotic Cardio-Vascular Disease</u> 1 yr.		INTERVAL BETWEEN ONSET AND DEATH <u>Arteriosclerotic Cardio-Vascular Disease</u> 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <u>Baltimore</u> (County) <u>Md.</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>57</u> , to <u>6/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/12</u> , 19 <u>57</u> , and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Baumgardner</u> M.D.		ADDRESS (Street, city or town, state) <u>Baltimore Md</u> DATE SIGNED <u>6/12/57</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 6-14-57</u>		22b. DATE THEREOF <u>6-14-57</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>OAK-LAWN</u>
22d. LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>M.D.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly - Essex</u>		ADDRESS <u>MUNI UNIT 171957</u>	24a. REGISTRY REGISTRAR <u>Edith Hussey</u>
			24b. REGISTRAR'S SIGNATURE

BUREAU Y.

JUN 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5959

## CERTIFICATE OF DEATH

05949  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)		If institution, Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		White Marsh	c. LENGTH OF STAY IN TB	c. STATE		Maryland	b. COUNTY	Baltimore
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Box 159 Bird River Grove Road	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?		White Marsh		
3. NAME OF DECEASED (Type or print)		First Mr. Richard P. Bentz	Middle	Last	4. DATE OF DEATH	Month June	Day 24	Year 1957
5. SEX		6. COLOR OR RACE	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
male		white		Nov. 20, 1887	69 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
Baltimore Transit Co Electrical					Baltimore, Maryland			USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
George Bentz		Marcella Fahey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		213-10-0331		Mrs. Katherine Bentz, Grove Road.		Box 159 Bird River		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinomatosis						
162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Bronchiogenic carcinoma						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from		14/29	19 57 to	6/24	19 57	that I last saw the deceased		
alive on		6/21	19 57	and that death occurred at	8: a.m.	from the causes and on the date stated above.		
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)						
George D. Edwards		9660 Belair Road, 6/24/57						
PHYSICIAN'S NAME (Type)		DATE SIGNED						
George D. Edwards.								
22a. BURIAL, CREMAT. ON, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)			(State)
Burial		6/27/57	Mt. Carmel Cemetery		Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck		5305 Harford Road #14		DATE JUN 26 1957		L. Miller Ferrell		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

RECEIVE

NY 3 2957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05950

5960

## CERTIFICATE OF DEATH

Reg. Dist. No.

HOSPITAL OR ATTEND PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md</i>		c. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Columbia</i>		c. LENGTH OF STAY IN 1b <i>1 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>1400 Park Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glen Hill Home</i>		d. STREET ADDRESS <i>13 Baltimore - 17</i>		d. DATE OF DEATH <i>June 15 1957</i>		e. Month Day Year Month Day Year 1957	
3. NAME OF DECEASED (Type or print) <i>James White Engle</i>	First <i>J</i>	Middle <i>White</i>	Last <i>Engle</i>	4. DATE OF BIRTH <i>June 05 1887</i>	5. AGE (In years lost birthday) <i>70 yrs.</i>	6. IF UNDER 1 YEAR Months <i>0</i>	7. IF UNDER 24 HRS. Days <i>0</i>
S SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 05 1887</i>	9. AGE (In years lost birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Hours <i>0</i>	11. IF UNDER 24 HRS. Min. <i>0</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Secretary Cambridge Md</i>		11. BIRTHPLACE (State or foreign country) <i>Cambridge Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Rev. Elias J. Bingley</i>		14. MOTHER'S MARRIED NAME <i>Ella J. Bingley</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-10-1540</i>	
				17. INFORMANT <i>Eliza J. Bingley</i>		Address <i>504 Virginia St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular Accident</i>		DUE TO <i>General Arterosclerosis</i>		DUE TO <i>General Arterosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>148 hours</i>	
DUE TO <i>General Arterosclerosis</i>		DUE TO <i>General Arterosclerosis</i>		DUE TO <i>General Arterosclerosis</i>		5 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>June 15 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>202 Cathedral St</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>December 1948 to June 1957</i> , that I last saw the deceased alive on <i>15 June 1957</i> , and that death occurred at <i>7:50 p.m.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>202 Cathedral St</i>							
SIGNATURE <i>J. Douglas Lockard</i>		DATE SIGNED <i>June 18 1957</i>					
PHYSICIAN'S NAME (Type) <i>J. Douglas Lockard</i>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 18, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Loudon Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore - 1, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Stuart Morris Jr</i>		ADDRESS <i>10845 Wilkinst</i>		24a. REC'D BY REGISTRAR <i>June 18 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Quinton</i>	

RECEIVED  
FBI BUREAU

JUN 18 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05951

5961

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN lb

15yr7mth4dys

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

SPRING GROVE STATE HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. STREET ADDRESS

1507 N. Monroe Street

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATHMonth  
JuneDay  
4  
Year  
19 57

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (In years  
from birthday)  
93 yrs

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days Hours Min

male

white

WIDOWED DIVORCED 

1863

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

carpenter

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Russia

U. S. A.

13. FATHER'S NAME

Isaac Blechman

14. MOTHER'S MAIDEN NAME

Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)  
If yes, give war or date of service)

unknown

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Records: SPRING GROVE STATE HOSPITAL

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute cardiac failure

INTERVAL BETWEEN  
ONSET AND DEATH

172.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last

(b)

Arteriosclerotic cardiovascular disease

DUE TO

(c) Generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19 p. m.20d. INJURY OCCURRED  
White Not white  
of work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from April 29, 1957, to June 4, 1957, that I last saw the deceased alive on June 4, 1957, and that death occurred at 1:56 p.m., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Greta Wachler

M.D. SPRING GROVE STATE HOSPITAL 6-4-57

PHYSICIAN'S  
NAME (Type)

Stella Wachsler, M. D.

Catonsville 28, Maryland

22a. BURIAL, CREMATION  
REMOVAL (Specify)

Burial 6-6-57

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Jack Lewis Inc 2100 Eutaw Place

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE

NUM 6 57

Signature

BUREAU V. S

JUN 6 1977

RECEIVED

5962 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		BALTIMORE Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b GLEN ARM		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTIMORE 23	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Douglas Middle A. Boblitz Last L.		4. DATE OF DEATH		Month 6	Day 18 Year 1957
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 14-1911	
9. AGE (In years last birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10b. KIND OF BUSINESS OR INDUSTRY Eng. Firm		11. BIRTHPLACE (State or foreign country) BALTO Md	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Douglas S. Boblitz Sr		14. MOTHER'S MOTHER'S MAIDEN NAME MARIE PITTLE		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no unknown) No		16. SOCIAL SECURITY NO. 713-07-4393		17. INFORMANT Hattie M. Boblitz		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 915.3 DUE TO Par Tra / Decapitation. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Body found Burns & 50% Body (c) 3rd Burns - Amputation Right lower leg	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIPTION OF INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) WELDING A PRESSURE TANK FULL OF OXYGEN - 180lb Pressure per sq inch		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20c. TIME OF INJURY Month, Day, Year Hour am. 6-18 1957 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) FACTORY		20f. (City or town) GLEN ARM (County) BALTO (State) Co Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles F. O'Donnell						DATE SIGNED 6/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 364-45		22b. DATE THEREOF 6-18-57		22c. NAME OF CEMETERY OR CREMATORIUM NEWCASTLE		22d. LOCATION (City, town, or county) BALTO (State) Md	
23. FUNERAL/DIRECTOR'S SIGNATURE X P. M. Walters		ADDRESS PRATT & CO STRICKER ST		24a. REC'D. BY REGISTRAR DATE 29 1957		24b. REGISTRAR'S SIGNATURE	

1 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or removal.

PEAU V. S.

JN 30 1957

DECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05953

5963

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>100 Berrymans Lane</b>		d. STREET ADDRESS <b>Berryman's Lane</b>	
e. LENGTH OF STAY IN lb <b>34 yrs</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Margaret</b>		First <b>Flynn</b>	Middle <b>Bollinger</b>
4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1957</b>		5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 28, 1873</b>	
9. AGE (in years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Patrick Flynn</b>		14. MOTHER'S MAIDEN NAME <b>Margaret</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>J. Edward Bollinger, Towson 4, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
DUE TO  Conditions, if any, which gave rise to Immediate cause (a), stating the under- lying cause last.  (b)  DUE TO  (c)		<b>Cardiac Failure</b>  <b>Arteriosclerosis, generalized</b>  <b>year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Towson</b> (County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>November</b> , 19 <b>53</b> , to <b>June 10</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 4</b> , 19 <b>57</b> , and that death occurred at <b>Kingsway</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. McWilliams</b>		ADDRESS (Street, city or town, state) <b>Reisterstown, Maryland</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>June 14, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13/47</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>June 14, 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>J. F. Eline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please sever carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

BUREAU V. S.  
RECEIVED  
JUN 13 1957

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5964 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

05954

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File Page 3 and 4 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Reisterstown</b>		c. LENGTH OF STAY IN lb <b>20 min.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Westminster Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Reisterstown</b>	
3. NAME OF DECEASED (Type or print) <b>Charles</b>		First <b>Russel</b>	Middle <b>Bosley Jr.</b>
4. DATE OF DEATH <b>June 7 1957</b>		Month <b>July</b>	Day <b>7</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>August 30, 1944</b>		9. AGE (In years from birthday) <b>12 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	11. BIRTHPLACE (State or foreign country) <b>California</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Russel Bosley, Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Myrtle Loyo</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles Russel Bosley Sr., Glen Falls Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address <b>Reisterstown, Md.</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>929.8</b>		DUE TO <b>Drowning- accidental</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b>		DUE TO <b>(c)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Went swimming and didn't come up.</b>	
20c. TIME OF INJURY Hour a. m. p. m. <b>June 7 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Liberty Reservoir Reisterstown, Balto., Md.</b>
20f. (City or town) <b>Reisterstown</b>		(County) <b>Baltimore</b>	
		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D. D. Caples</i>		DATE SIGNED <b>6-10-57</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jun 10, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville 8 Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Newell, Pikesville</i>		24a. REC'D BY REGISTRAR <b>JUN 11 1957</b>	
		24b. REGISTRAR'S SIGNATURE <i>Frank J. Newell, Pikesville</i>	

BUREAU Y.

JUN 11 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05955

## 5965 CERTIFICATE OF DEATH

Reg. Dist. No. 3c

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>1yr 2mth 4dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>3 Burke Avenue #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Margaret</b>	Middle <b>Grace</b>	Last <b>Bowen</b>	4. DATE OF DEATH <b>June 21 1957</b>	Month <b>June</b>	Day <b>21</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>about 1870</b> <b>unrecd</b>	9. AGE (In years last birthday) <b>87 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John McGlocklin</b>				14. MOTHER'S MAIDEN NAME <b>Harriett Heath</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>42 d.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>fun'l brain disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>injury</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 11, 1956</b> , to <b>June 21, 1957</b> , that I last saw the deceased alive on <b>June 21, 1957</b> , and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>ACTUAL SIGNATURE</b> <b>John Vasconcellos M.D.</b>							
PHYSICIAN'S NAME (Type)		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Tolson</b>		ADDRESS <b>1010 E. 36th St. Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>John J. Tolson</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. French</b>	

RECEIVED  
BUREAU V. S.

JUN 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5966

## CERTIFICATE OF DEATH

05956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Catonsville - 28		c. LENGTH OF STAY IN 1b Woodlawn X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		d. STREET ADDRESS 1810 Colonial Road-Balto. 7, Md.	
3. NAME OF DECEASED (Type or print)  MARY		4. DATE OF DEATH Month Day Year June 26 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Frederick Simms		14. MOTHER'S MAIDEN NAME Marcella Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mr. Clarence R. Bowen-Box 25-Prince Frederick, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO  (c)		INTERVAL BETWEEN ONSET AND DEATH 3-5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/2 1957 to 6/26 1957, that I last saw the deceased alive on 6/24 1957, and that death occurred at 1A M.D. 6410, from the causes and on the date stated above. ACTUAL SIGNATURE Milton Schapiro PHYSICIAN'S NAME (Type) Milton Schapiro Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/57	
22c. NAME OF CEMETERY OR CREMATOR Y Meadowridge Mem. Pk. Cen.		22d. LOCATION (City, town, or county) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Ticknor & Sons		ADDRESS North Pa Aves	
24a. REC'D BY REGISTRAR DATE JUL 1 '57		24b. REGISTRAR'S SIGNATURE Albermarle	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be revised by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

RECEIVED  
BUREAU V. S.

NOV 19 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be reported by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 31			
5967 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			c. LENGTH OF STAY IN lb 16 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn			d. STREET ADDRESS 5408 W. North Ave.,			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5408 W. North Ave.,													
3. NAME OF DECEASED (Type or print) Carrie Lillian					First	Middle	Last	4. DATE OF DEATH Month June Day 19, Year 1957					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1895			9. AGE (In years less birthday) 62 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY --			11. BIRTHPLACE (State or foreign country) Va.			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME William Wenner					14. MOTHER'S MAIDEN NAME Mary C. Orisson								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. no			17. INFORMANT Willian N. Boyd		Address 5408 W. North Ave.,						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>154X</b> DUE TO <b>METASTATIC CARCINOMA TO THE LIVER; LIVER FAILURE</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause lost.</u> (b) <b>ADENOCARCINOMA OF THE RECTOSIGMOID COLON</b> <b>9 months</b> (c) <b></b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <b>1950</b> , to <b>June 19, 1957</b> , that I last saw the deceased alive on <b>JUNE 18, 1957</b> , and that death occurred at <b>6:00A.M.</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>M.D. 5101 Gwynn Oak Ave. Baltimore, 7, Maryland</b> DATE SIGNED <b>19 June 1957</b>			
ACTUAL SIGNATURE <b>Millard T. Traband Jr. M. D.</b>													
PHYSICIAN'S NAME (Type)		22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>								22b. DATE THEREOF <b>6-22-1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Rose Hills</b>	22d. LOCATION (City, town, or county) <b>Hagerstown, Md.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong 3207 W. NORTH AVE.</b>										24a. ADDRESS <b>DATE 21 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Jim Marion</b>		

BUREAU V. S

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05958

5968

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/1 Freeland, Maryland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Freeland, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Norman		First	Middle	Last	4. DATE OF DEATH Briggs	Month	Day	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Sept. 22, 1910	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sander		10b. KIND OF BUSINESS OR INDUSTRY furniture fact.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Ferdinand Briggs		14. MOTHER'S MAIDEN NAME Emily Kurtz						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 071-07-4344		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary thrombosis		INTERVAL BETWEEN ONSET AND DEATH				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Myocardial infarction						
DUE TO (c) Cardiovascular disease								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 44-5-1						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Maryland		(County)		(State)
21. I certify that I attended the deceased from May 16, 1957, to June 13, 1957, that I last saw the deceased alive on June 13, 1957, and that death occurred at 1:00 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE Stella Wachsler		M.D.		SPRING GROVE STATE HOSPITAL 6-13-57				
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 15/1957		22c. NAME OF CEMETERY OR CREMATORIAL Maryland Line Cemetery		22d. LOCATION (City, town, or county) Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Dwight Harlan, New Freedom Pa.		ADDRESS		24a. REC'D BY REGISTRAR JUN 17 '57		24b. REGISTRAR'S SIGNATURE Altman		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1  
 may be signed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

JUN 17 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05959

## CERTIFICATE OF DEATH

Reg. Dist. No. 3

1 PLACE OF DEATH a. COUNTY <i>Baltimore STATE TRAINING Rosewood School MARYLAND</i>		2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Balto. City</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills, MD</i>		c. LENGTH OF STAY IN lb RURAL AND GIVE NEAREST TOWN <i>Baltimore</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood STATE TRAINING School</i>		d. STREET ADDRESS <i>1310 North Washington Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <i>Alfred</i>	Middle Last <i>Brooks</i>	4. DATE OF DEATH <i>6 15 1957</i>	Month <i>6</i>	Day <i>15</i>	Year <i>1957</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-18-29</i>	9. AGE (in years last birthday) <i>27 yrs.</i>	10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS Days <i>13</i>	Hours <i>0</i>	Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>deceased</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>deceased</i>		14. MOTHER'S MAIDEN NAME <i>deceased</i>		Address <i>1107 St. Rosewood Ave</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Brother Mr. Charles Brooks BALT. MD.</i>		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Renal hypertension</i>		(b) DUE TO <i>Nephrosclerosis</i>		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Congenital epilepsy</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6/13/1957</i>		20f. (City or town) <i>6/13/1957</i>		(County) <i>6/13/1957</i>	(State) <i>6/13/1957</i>
21. I certify that I attended the deceased from <i>7/3/36</i> , to <i>6/13/1957</i> , that I last saw the deceased alive on <i>6/13/1957</i> , and that death occurred at <i>3:45 pm</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Rich. Hindenberg, M.D.</i> DATE SIGNED <i>6/14/57</i>									
ACTUAL SIGNATURE <i>Rich. Hindenberg</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 17, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rosewood</i>		22d. LOCATION (City, town, or county) <i>Owings Mills, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Eline &amp; Sons, Reisterstown, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>Date 6-17-57</i>		24b. REGISTRAR'S SIGNATURE <i>Mary B. Shire</i>			

BUREAU U. S.

JUN 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7

5970

## CERTIFICATE OF DEATH

Reg. Dist. No.

05960

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 60 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeaway Manor Nursing Home		d. STREET ADDRESS Formerly of 760 Poplar Grove St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frederick	Middle b. Brunshear	Last
4. DATE OF DEATH	Month June	Year 1957	Day 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1876
9. AGE (In years [at birthday]) yrs 81		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Our Inspector		10b. KIND OF BUSINESS OR INDUSTRY B. & O. R. R.	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Brunshear		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT Mrs. Helen A. Shirey, 1919 Frederick Ave		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Trauma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 20 hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> Hyper tension Cardiovascular Disease		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC. 10, 1955 to JUNE 18, 1957, that I last saw the deceased alive on JUNE 18, 1957, and that death occurred at 12:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John F. Schaefer M.D.		ADDRESS (Street, city or town, state) 401 RANDOM RD. BALTO. 29 MD.	
PHYSICIAN'S NAME (Type) JOHN F. SCHAEFER		DATE SIGNED June 19, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 21/57	
22c. NAME OF CEMETERY OR CREMATORIAL Western		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR JUN 2 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Alvin	

RECEIVED  
UNIVERSITY OF TORONTO LIBRARIES

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5971 CERTIFICATE OF DEATH**

05961  
 31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore MARYLAND		a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3413 Kimble Road		d. STREET ADDRESS 3413 Kimble Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Leonard F. Bull		First	Middle
		Last	4. DATE OF DEATH June 25, 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Writer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Leonard F. Bull		14. MOTHER'S MAIDEN NAME Ella C. Wooden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-01-4857	17. INFORMANT Mrs. Alice M. Bull 3413 Kimble Road, Rockdale
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 462.1		Refracted esophageal Varix Congestive heart failure & anemia 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ 4/10, 1955, to _____ 6/25, 1957, that I last saw the deceased alive on _____ 6/24, 1957, and that death occurred at 6:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 8204 LIBERTY Rd 6/28/57 DATE SIGNED	
ACTUAL SIGNATURE <i>Edwin F. P. Murphy</i>		PHYSICIAN'S NAME (Type) EDWIN L. P. (ERPONT) MD BALTIMORE, Md	
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 28, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home 3631 Falls Road Balto.		22d. LOCATION (City, town, or county) Baltimore Co., Maryland 24o. REC'D. BY REGISTRAR DATE JULY 1 1957 REGISTRAR'S SIGNATURE <i>Horace F. Burgee</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 so it can be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 1 1957

BUREAU W. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5972

## CERTIFICATE OF DEATH

Reg. Dist. No.

05962  
44

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>4 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>409 E. Fort Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>R.</b>	Last <b>BUSICK</b>	4. DATE OF DEATH Month <b>June</b>	Day <b>19</b>	Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 25, 1886</b>	9. AGE (In years (at birthday) yrs. <b>70</b> )	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George L. Busick</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elliott</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>460.1</b>		MYOCARDIAL INFARCTION WITH HEMOPERICARDIUM		INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		CORONARY THROMBOSIS		UNKNOWN			
DUE TO <b>VA</b>							
DUE TO <b>VA</b>							
DUE TO <b>VA</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>VA</b>	Month <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baltimore National Cem.</b>	20f. (City or town) <b>Baltimore</b>	(County) <b>Maryland</b>	(State) <b>Maryland</b>	
21. I certify that I attended the deceased from June 15, 1957, to June 19, 1957.							
X and that death occurred at 8:50 P.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>6/20/57</b>	
ACTUAL SIGNATURE <i>Armen Bogosian</i>	PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN, M.D.</b>		M.D. VAH, FORT HOWARD, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-24-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. McCully Funeral Home, 237 Patapsco, Baltimore, Md.</b>		ADDRESS <b>JUN 24 1957</b>	24a. REC'D BY REGISTRAR <b>James L. McCully</b>	24b. REGISTRAR'S SIGNATURE <b>James L. McCully</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 21 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05963

5973

## CERTIFICATE OF DEATH

Reg. Dist. No.

45

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be signed by the hospital or attending physician;**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, it may be detached for use of the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		b. COUNTY					
				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		7902 Philadelphia Road		d. STREET ADDRESS		7902 Philadelphia Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Lawrence	Middle J.	Last Butala Sr.	4. DATE OF DEATH	Month June	Day 9		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 5, 1904	53 yrs	Months	Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Steel Worker				Farrell, Pennsylvania					
13. FATHER'S NAME Stephen Butala				14. MOTHER'S MAIDEN NAME Anna Halvska					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
		149-16-4880		May W. Butala		7902 Philadelphia Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO (b)  DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
INTERVAL BETWEEN ONSET AND DEATH									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from alive on		1957						DATE SIGNED	
ACTUAL SIGNATURE:  PHYSICIAN'S NAME (Type)		ADDRESS (Street, City or town/state) 914 N. Charles St.						DATE SIGNED 6/11/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 12, 1957		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn		22d. LOCATION (City, town, or county) Baltimore Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street		ADDRESS		24a. REC'D BY REGISTRAR JUN 12 1957		24b. REGISTRAR'S SIGNATURE Edith K. Lipp			

RECEIVED

JUN 12 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5974 CERTIFICATE OF DEATH

05964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYEVILLE</b>		c. LENGTH OF STAY IN 1b <b>1 YEAR - 8 MO</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>75 WEST MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>HELEN</b>	Middle <b>G.</b>	Last <b>CALLOWELL</b>	4. DATE OF DEATH <b>JUNE</b>	Month <b>JUNE</b>	Day <b>21</b>	Year <b>1957</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-7-1881</b>	9. AGE (In years last birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES C. GORSUCH</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE CONKLING</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Frank L. Smith Jr. - Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<b>arterio-mitral Cardiac</b>		<b>Vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 mo.</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. p. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-28</b> , 1955, to <b>10-19</b> , 1957, that I last saw the deceased alive on <b>10-19</b> , 1957, and that death occurred at <b>4:55 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter T. Lewis</b>		M.D.		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>		DATE SIGNED <b>6/21/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/25/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Frostburg Memorial Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frostburg</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook Inc.</b>		ADDRESS <b>1217 St. Paul Street Baltimore</b>		24a. REC'D BY REGISTRAR <b>24. REGISTRAR'S SIGNATURE <b>Alfred Cook</b></b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

VS A15 (4)  
 15M 9/55

BUREAU V. S.

JUN 24 1977

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05965 41

5975

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>32 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>WHITEHALL ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>SKIPWITH</b>	Middle	Last <b>CANNELL</b>	4. DATE OF DEATH <b>JUNE 15 1957</b>	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>DECEMBER 22, 1887</b>	9. AGE (In years from birthday) <b>69 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>ECONOMIST</b>		10b KIND OF BUSINESS OR INDUSTRY <b>INTERSTATE COMMERCE RESEARCH SECTION</b>		11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA, PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SKIPWITH CANNELL, SR.</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN MILLER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>WW-1</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>148x CARCINOMA OF THE PHARYNX WITH METASTASES</b>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BRONCHOPNEUMONIA BILATERAL</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Hour o. m. p. m.	Month 19	20d INJURY OCCURRED White at work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) <b>FORT HOWARD, MARYLAND</b>	(County)	(State)	
21. I certify that I attended the deceased from <b>MAY 14, 1957</b> to <b>JUNE 15, 1957</b> , and that death occurred at <b>10:18 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Armen Bogosian</i>	ADDRESS (Street, city or town, state) <b>FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>6-16-57</b>				
PATIENT'S NAME (Type) <b>ARMEN BOGOSSIAN</b>	M.D. FORT HOWARD, MARYLAND		6-16-57				
22a BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b DATE THEREOF <b>6-21-57</b>	22c NAME OF CEMETERY OR CREMATORIUM <b>ARLINGTON NATIONAL CEMETERY</b>	22d LOCATION (City, town, or county) <b>ARLINGTON, VIRGINIA</b>	(State)			
23 FUNERAL DIRECTOR'S SIGNATURE <i>John Cook-Bright, Inc.</i>	ADDRESS <b>William Cook-Bright, Inc., Funeral Home 6009 Harvard Road, N.W., Washington, D.C.</b>	24a REC'D BY REGISTRAR <b>DATE 6-21-57</b>	24b. REGISTRAR'S SIGNATURE <i>John Cook-Bright</i>				

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After his certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
1SM 9/55

SHIPPED TO: W. W. CHAMBERS, 1400 CHAPIN STREET, N. W. WASHINGTON, D. C.

BUREAU V. S.

ON 11/17/72

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5976

## CERTIFICATE OF DEATH

05966

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN Tb <b>73 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and g've nearest town) <b>STOCKTON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		d. STREET ADDRESS <b>P.O. Box 91-A, ROUTE #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>HARRY</b>	Middle <b>S</b>	Last <b>CANNON</b>	4. DATE OF DEATH <b>JUNE 16</b>	Month <b>JUNE</b>	Day <b>16</b>	Year <b>19 57</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 3, 1921</b>	9. AGE (In years lost birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OYSTER SHUCKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OYSTER PACKING &amp; SHIPPING COMPANY</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ASBURY CANNON</b>				14. MOTHER'S MAIDEN NAME <b>CAROLINE KNOX</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>		16. SOCIAL SECURITY NO <b>WW-11</b>		17. INFORMANT <b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  (b)  DUE TO  (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>MALIGNANT HYPERTENSION WITH CEREBROVASCULAR ACCIDENT</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL 3, 1957</b> , to <b>JUNE 16, 1957</b> , and that death occurred at <b>7:12 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>							
DATE SIGNED <b>6/17/57</b>							
ACTUAL SIGNATURE <i>Irving Freeman</i>							
PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/17/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Horntown Methodist Cem.</b>		22d. LOCATION (City, town, or county) <b>HOINTOWN, VIRGINIA</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Worden &amp; Savage Funeral Home, New Church, Virginia</b>				24a. REC'D BY REGISTRAR <b>6/17/57</b>		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>	

BUREAU Y.

JUN 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05967

5977

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		d. STREET ADDRESS <b>516 N. Rolling Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>516 N. Rolling Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Alexander</b>	Middle <b>W.</b>	Last <b>Carr</b>	4. DATE OF DEATH	Month <b>June</b>	Day <b>17,</b>	Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Mar. 16, 1881</b>	9. AGE (in years lost birthday) <b>76</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>76</b>	Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>George R. Carr</b>				14. MOTHER'S MAIDEN NAME <b>Mary Alice Daniels</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Raymond E. Carr 1525 Linden Ave., (17)</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; Chronic Congestive Heart Failure.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Cor Pneumonitis.</b> (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bronchitis &amp; Emphysema</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>6/17/57</b> (County) <b>6/17/57</b> (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. Signature: <b>W. E. McGrath</b> M.D. <b>1303 Frederick Rd</b> ADDRESS (Street, city or town, state) <b>Catonsville 28 Md</b> DATE SIGN'D <b>6/18/57</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-19-1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Western</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. Howard Strong</b>		ADDRESS <b>3267 W. North Ave.</b>		24a. REC'D BY REGISTRAR <b>JUN 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. Smith</b>		

BUREAU V.

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2718 Frederick Road		d. STREET ADDRESS 2718 Frederick Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MILDRED AUGUSTA Middle CAVELY Lost	4. DATE OF DEATH June 4, 1957	Month	Day	Year	
Female White WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 4, 1904	9. AGE (In years from birthday) 52 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY Drug Store	11. BIRTHPLACE (State or foreign country) Howard County, Md.			
13. FATHER'S NAME Roswell Cavey		14. MOTHER'S MAIDEN NAME Lilly Cougle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 216-10-8027	17. INFORMANT Margaret L. Cavey, 24 W. Loch Lane, Richmond, Va.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive subarachnoid hemorrhage due to rupture of aneurysm of right anterior cerebral artery					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Will V. Lovitt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/6/57
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-7-57	22c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Memorial	22d. LOCATION (C'ty, town, or county) Dorsey, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Frank C. Higinbotham, Ellicott City, Md.		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S S.G.NATURE <i>W.Lovitt</i>	
			DATE JUN 10 '57		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, removal, or removal.

BUREAU Y.

UN 10 1957

REGELY ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05969

5979

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Carmine</i>		c. LENGTH OF STAY IN 16 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING-GROVE ST. HOSPITAL</b>	
d. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		e. STREET ADDRESS <b>6 S. CASTLE AVE.</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>EDWARD</b>	Middle <b>F.</b>	Last <b>CHAMBERLAIN</b>
4. DATE OF DEATH	Month <b>6</b>	Day <b>1</b>	Year <b>1957</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-24-1902</b>
9. AGE (In years last birthday) <b>54 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN CHAMBERLAIN</b>		14. MOTHER'S MAIDEN NAME <b>DORA LASSNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES UNKNOWN</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>SOPHIE CHAMBERLAIN</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-7-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Address <b>6 S. CASTLE AVE. BALTO.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 13, 1957</b> to <b>Janet 1957</b> , that I last saw the deceased alive on <b>1957</b> , and that death occurred on <b>6-25 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b>	
ACTUAL SIGNATURE <i>William N. Karn, Jr., M.D.</i>		DATE SIGNED <b>6-1-57</b>	
PHYSICIAN'S NAME (Type) <b>William N. Karn, Jr., M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial June 4, 1957 at Stanislaus</b>		22b. DATE THEREOF <b>June 4, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Stanislaus</b>
22d. LOCATION (City, town, or county) <b>Baltimore Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dr. J. C. M. Walker</i>		24a. ADDRESS <b>1216 W. 32nd St. Brooklyn</b>	24b. REC'D BY REGISTRAR DATE <b>JUN 8 '57</b>
		REGISTRAR'S SIGNATURE <i>John E. Wilson</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
RECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director.  
This certificate may be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 in any event within 72 hours after death.

BUREAU Y.

1957

NO. 621 V E D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05971

33

**Reg. Dist. No.**

5930

## **CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) b. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Owings Mills</b>			c. LENGTH OF STAY IN 1b <b>17 yrs.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Owings Mills</b>		
			d. STREET ADDRESS <b>Reisterstown Road</b>		
3. NAME OF DECEASED (Type or print) <b>Delia</b>			First	Middle	Last <b>Chenoweth</b>
4. DATE OF DEATH <b>June 26, 1957</b>			Month	Day	Year
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1877</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Dundalk, Ireland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Nicholas Boyle</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Mr. A. Paul Chenoweth, Reisterstown Rd.</b>	Address <b>Owings Mills, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumococosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>		
15/x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause first. <b>Ca. of stomach</b>			3 yrs.		
DUE TO <b>none</b>					
DUE TO <b>none</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>none 19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>	(County) (State) <b>none</b>
21. I certify that I attended the deceased from <b>7-24-44</b> , 19_____, to <b>6-26-57</b> , 19_____, that I last saw the deceased alive on <b>6-26-57</b> , 19_____, and that death occurred at <b>11:45A</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>D. D. Caples</b>			ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b>		
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>			DATE SIGNED <b>6-28-57</b>		

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be revised by the hospital or attending physician.

**DOCTOR:** After this certi cate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5 A15 (4)  
15M 9/55

REGATIVE

1957

MEAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5981

## CERTIFICATE OF DEATH

05971  
L4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 326 East 20th Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HOWARD	Middle T.	Last CHENOWETH	4. DATE OF DEATH June	Month Month	Day 19	Year 1957
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 11, 1894	9. AGE (In years at birth) 63	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Repairman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Towson, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Chenoweth		14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW I 705-10-8819		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5971 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		CONGESTIVE HEART FAILURE				INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
(b) DUE TO COR PULMONALE						UNKNOWN	
(c) DUE TO PULMONARY EMPHYSEMA						UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4544.3						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19 VA		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8:25AM, June 18, 1957, to 1:05PM, June 19, 1957. XXXXXXXXXX XXXXXX and that death occurred at 1:05PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state)						DATE SIGNED 6/19/57	
ACTUAL SIGNATURE ARMEN BOGOSIAN		M.D.		VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) ARMEN BOGOSIAN, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-21-57		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight, Inc.		ADDRESS Wm. Cook Blight, Inc., 6009 Harford Rd., Balt. Md.		24a. REC'D. BY REGISTRAR DATE 6/21/57		24b. REGISTRAR'S SIGNATURE Lawson L. Harvey	

BUREAU V. S

JUN 24 1977

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5982

## CERTIFICATE OF DEATH

0597238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE	
<i>Baltimore</i> <i>MARYLAND</i>		<i>Md.</i> <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Silverdale</i> <i>at home</i>		<i>"Silverdale"</i> <i>900 Silverbrook</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>at home</i>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Richard T. Philes</i>		<i>Richard</i>	<i>Tubman</i>
4. DATE OF DEATH		Month	Day
		<i>June</i>	<i>4</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Male</i>		<i>White</i>	<i>Sept-6-1881</i>
8. DATE OF BIRTH		9. AGE (In years less birthday) yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
		<i>35</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
<i>Clerk</i>		<i>Cumberland Ky. - Kentucky U.S.</i>	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Richard T. Philes</i>		<i>Sarah Sanders</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>			
17. INFORMANT		Address	
<i>Mrs. Mattie Philes 4100 Lombard</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Pneumonia, Lobar right upper six days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) DUE TO <i>Bronchogenic carcinoma right upper</i>		<i>1 year</i>	
(c) <i>Metastatic Ca. to lumbar vertebra</i>		<i>2 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Fracture neck left femur Oct. 56</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
		<i>Fracture neck left femur Oct. 56</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1st</i> , 19 <i>56</i> , to <i>June 4th</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>June 4th</i> , 19 <i>57</i> , and that death occurred at <i>2:03 PM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Robert Z. Berry</i>		M.D. <i>101 W. Read St</i>	
PHYSICIAN'S NAME (Type) <i>Robert Z. Berry, M. D.</i>		101 W. Read St., Medical Arts Building (1)	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Cremation</i>		22b. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Grove</i>	
22c. LOCATION (City, town or county) <i>Portsmouth Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clifford Marshall, New York, Bell</i>		24a. REC'D. BY REGISTRAR, DATE <i>10 1957</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>John Lewis</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUN 31

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5983

## CERTIFICATE OF DEATH

05973  
44

Reg. Dist. No.

## PLACE OF DEATH

o COUNTY  
BALTIMORE

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FORT HOWARD

## c. LENGTH OF STAY IN lb

31 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

VETERANS ADMINISTRATION HOSPITAL

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

THOMAS

L.

CHRISTIAN

4. DATE  
OF  
DEATH

JUNE

29

19 57

## 5. SEX

MALE

## 6. COLOR OR RACE

WHITE

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

## 8. DATE OF BIRTH

AUGUST 10, 1905

9. AGE (In years  
lost birthday)

51 yrs

## 10. IF UNDER 1 YEAR

Months Days

## 11. IF UNDER 24 HRS

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

EDITOR &amp; PUBLISHER

10b. KIND OF BUSINESS OR INDUSTRY

MAGAZINE FIRM

11. BIRTHPLACE (State or foreign country)

RICHMOND, VA.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

CHARLES M. CHRISTIAN

## 14. MOTHER'S MAIDEN NAME

GRACE CHRISTION

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes or no or unknown)  
(If yes, give war or dates of service)

YES

WW II

## 16. SOCIAL SECURITY NO.

214-05-1106

## 17. INFORMANT

Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.

## Address

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

HODGKIN'S DISEASE

INTERVAL BETWEEN  
ONSET AND DEATH  
UNKNOWN

## DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.  
(b)

## DUE TO

## (c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

ASCITES

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. 19  
p. m.

## 20d. INJURY OCCURRED

White Not while  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that I attended the deceased from May 29, 1957, to June 29, 1957, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Armen Bogosian M.D. Veterans Administration Hospital 6/30/57

PHYSICIAN'S  
NAME (Type)

ARMEN BOGOSTAN, M. D.

Fort Howard, Maryland

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

July 2, 57

## 22c. NAME OF CEMETERY OR CREMATORIUM

Lorriane Cemetery

## 22d. LOCATION (City, town, or county)

Woodlawn, Maryland

## (State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Richard J. Singleton

## ADDRESS

SINGLETTON FUNERAL HOME, Green Hwy, Glen Burnie, MD.

JULY 2, 1957 Dawson & Farley  
REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

BUREAU V. S.

1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05974

5984

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore County MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home 329 Harlem Avenue			d. STREET ADDRESS 2326 Aiken Street		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First George	Middle S.	Last Clark	4. DATE OF DEATH June 6 1957
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 28, 1888	9. AGE (In years 68 [lost birthday] yrs.)	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (Ret'd)			10b. KIND OF BUSINESS OR INDUSTRY Md. Dry Dock Co.,	11. BIRTHPLACE (State or foreign country) Richmond, Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Spooner Clark			14. MOTHER'S MAIDEN NAME Georgiana McCormick		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> [Yes, no, or unknown] no			16. SOCIAL SECURITY NO.	17. INFORMANT Wilbur F. Clark, 2326 Aiken Street, Baltimore 18	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 days  Myocardial failure & Hgt BP. unknown		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from June 1, 1957, to June 6, 1957, that I last saw the deceased alive on June 5, 1957, and that death occurred at 1234 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE CLIFFE RATLIFF, M.D. 4605 EDMONDSON AVE. 6/1/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-8-57	22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart Cemetery	22d. LOCATION (City, town, or county) Baltimore	(State)
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street			24a. REC'D BY REGISTRAR Allen 7 '57	24b. REGISTRAR'S SIGNATURE Albert Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

UN 10 1957

REGELIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5985

## CERTIFICATE OF DEATH

05975

Reg. Dist. No.

## 1. PLACE OF DEATH

Baltimore MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
OR and give nearest town) LENGTH OF STAY  
(in this place)

TOWN Baltimore, Md.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS 2616 Proctor Lane3. NAME OF  
DECEASED:  
(First)  
(Type or Print)

Mary Augusta Clark

(Middle)

(Last)

(First)

(Middle)

(Last)



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5937

## CERTIFICATE OF DEATH

05976  
41

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1907 Tyler Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
3. NAME OF DECEASED (Type or print) First THOMAS Middle L. Last CLARK		4. DATE OF DEATH Month June Day 29, Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.	
10c. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Savanah Carter	
15. WAS DEFASSED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
NO		17. INFORMANT Mrs. Erma M. Clark - 1907 Tyler Rd., Dundalk, Md.	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, Cancer of Stomach</i>		INTERVAL BETWEEN ONSET AND DEATH 78 mos	
151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct. 1956</i> to <i>June 1957</i> , that I last saw the deceased alive on <i>June 27, 1957</i> , and that death occurred at <i>6:45 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>M.B. Davis</i>		ADDRESS (Street, city or town, state) <i>6800 Mornungton Blvd</i> DATE SIGNED <i>22. BURIAL, CREMATION, REMOVAL (Specify) Burial</i>	
22b. DATE THEREOF <i>7/2/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cem.</i>	
22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Wickner &amp; Sons - Baltimore</i>		24a. REC'D BY REGISTRAR DATE <i>7/2/57</i>	
ADDRESS <i>17</i>		24b. REGISTRAR'S SIGNATURE <i>J. E. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refilled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 & 2 should be filled in by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. 2

11 3 1957

RECEIVED

05977

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

5986

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN lb <b>Approx. 2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		d. STREET ADDRESS <b>8804 Glenroy Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Robert</b>	Middle <b>Burgess</b>	Last <b>Clubb</b>	4. DATE OF DEATH	Month <b>June</b>	Day <b>25</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/1899</b>	9. AGE (in years last birthday) <b>57 yrs</b>	IF UNDER 1 YEAR Months <b>57</b>	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Handyman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Clubb</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Rutue</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>214-16-1224</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Skull Fracture</b> INTERVAL BETWEEN ONSET AND DEATH 2 min.							
778X DUE TO <b>Fracture right ankle</b> 2 min.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Fracture both knees</b> 2 min.							
DUE TO <b>Mental Depression</b> 2 mo.							
(c) <b>Pulmonary Tuberculosis</b> 2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Jumped from 8th floor Hospital window</b>					
20c. TIME OF INJURY Hour <b>9:30 AM</b>		Month, Day, Year <b>6 25 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mt. Wilson Hosp.</b>	20f. (City or town) <b>Mt. Wilson</b>	(County) <b>Balto.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>D. D. Caples</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>6/25/57</b>
EXAMINER'S NAME (Type) <b>D. D. CAPLES, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-28-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>ST PETER'S CEM</b>	22d. LOCATION (City, town, or county) <b>Balto. Md.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Zim Cook-Blight Inc. (CCG HARPER) PD</i>	ADDRESS	24a. REC'D BY REGISTRAR <b>D</b>	24b. REGISTRAR'S SIGNATURE <i>Dorothy Lewis</i>				
VS. A15ME(S) SM 9/55		DATE <b>6/26/57</b>					

BUREAU V. S.

500 ~ IN

RECEIVED

**Beg. Dist. No.**

**O DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

**O FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registration or cancellation.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE Maryland b. COUNTY Baltimore	
Towson		life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS York Rd	
Padonia Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
David				Cofield	June 16 1957
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-27-47	9. AGE (in years, last birthday) 9 yrs.
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>			IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Carroll E. Cofield, Sr.		14. MOTHER'S MAIDEN NAME Annabelle Ensor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Carroll E. Cofield, Sr., Cockeysville, Md.	
Address				INTERVAL BETWEEN ONSET AND DEATH Sudden	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO _____ Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Slipped off edge of quarry into water & failed to reapp. ear found beneath boat loft below surface of water.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. While at work <input type="checkbox"/> of work <input type="checkbox"/> p. m. 6-16-579		20d. INJURY OCCURRED Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Lindsay's Quarry	
(County)		(City or town)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Charles F. Donnell		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/17/57	
EXAMINER'S NAME (Type) Charles F. C. Donnell					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-19-57		22c. NAME OF CEMETERY OR CREMATORIAL Black Rock	
				22d. LOCATION (City, town, or county) Butler Maryland	
				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service 622 York Rd Towson, Md.					
ADDRESS					
24a. REC'D BY REGISTRAR JUN 18 '57					
24b. REGISTRAR'S SIGNATURE Charles F. C. Donnell					

RECEIVED  
BUREAU V. S.  
JUN 18 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5988 CERTIFICATE OF DEATH

059798

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) o STATE <b>Florida</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Miami</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>601 Fairway Drive</b>				d. STREET ADDRESS <b>1601 N.E. 109th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Mrs. Audrey A. Cofran</b>		First	Middle	Last	4. DATE OF DEATH <b>June 2nd</b>	Month	Day	Year <b>1957</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1910</b>	9. AGE (In years lost birthday) <b>46 yrs</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Beautician</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Harry V. Ardisson</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Proctor</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>217-01-4704</b>		17. INFORMANT <b>Mr. Edward L. Cofran, 601 Fairway Drive</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>1979</b>		DUE TO <b>Bronchopneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <b>Absocarcinoma - primary site unknown</b>		4 months				
		(c) <b>Metastatic Absocarcinoma of Brain, Spine + Thorax</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>1331 East North Avenue</b>		(County) <b>Baltimore, Maryland</b>		(State) <b>MD</b>
21. I certify that I attended the deceased from <b>May 28, 1957</b> , to <b>June 2nd, 1957</b> , that I last saw the deceased alive on <b>June 2nd, 1957</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>1331 East North Avenue</b>		DATE SIGNED <b>6/3/1957</b>		
ACTUAL SIGNATURE <b>Samuel B. Wolfe</b>								
PHYSICIAN'S NAME (Type) <b>Dr. Samuel B. Wolfe</b>								
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State) <b>MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>		

RECEIVED

JULY 24 1968

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05980

5989

## CERTIFICATE OF DEATH

Reg. Dist. No. 63

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4602 Ridgeway Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Bessie	Middle Mae	Last Cooper
4. DATE OF DEATH	Month June	Day 15,	Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 19, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clayton Wheeler		14. MOTHER'S MAIDEN NAME Annie Shaeffer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-7934	
17. INFORMANT Mr. Orville Cooper		Address 4602 Ridgeway Ave. 6	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of Stomach</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1949, to <u>June 15, 1957</u> , that I last saw the deceased alive on <u>June 10, 1957</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Max R. English</u> M.D. DATE SIGNED <u>6-17-57</u> PHYSICIAN'S NAME (Type) <u>Max R. English M.D.</u> <u>Baltimore 6 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jackson Funeral Home</u>		ADDRESS 7701 Belair Rd.	
		24a. REC'D BY REGISTRAR DATE JUN 18 1957	
		24b. REGISTRAR'S SIGNATURE <i>Entered in Registry</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5990 CERTIFICATE OF DEATH

05981

Reg. Dist. No.  
*45*

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived) II institution Residence before admission a. STATE <i>MD.</i> b. COUNTY <i>BALTO.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ESSEX</i>		c. LENGTH OF STAY IN 1b <i>4 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ESSEX</i>		d. STREET ADDRESS <i>904 GARDEN DRIVE</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>904 GARDEN DRIVE</i>				d. STREET ADDRESS <i>904 GARDEN DRIVE</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>Roserta</i>	Middle <i>L</i>	Last <i>CORN</i>	4. DATE OF DEATH <i>JUNE 5 1957</i>	Month <i>JUNE</i>	Day <i>5</i>	Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>MARCH 14-1875</i>	9. AGE (In years lost birthday) <i>82 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO. MD.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>DULLA</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <i>- - -</i>		17. INFORMANT <i>MILTON D. CORNS</i>		Address <i>SANIE ASARINE</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b) Generalized arteriosclerosis.		Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>		
DUE TO (c) Heart failure						Several years		
						2 1/2 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Myocardial fibrillation</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>April</i>	Day <i>9</i>	Year <i>1957</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>413 Eastern Ave. Essex Md.</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>April 9, 1957</i> , to <i>June 1, 1957</i> , that I last saw the deceased alive on <i>June 1, 1957</i> , and that death occurred at <i>11 P.M.</i> on <i>June 5, 1957</i> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>413 Eastern Ave. Essex Md.</i> DATE SIGNED <i>6/8/1957</i>								
MEDICAL CERTIFICATION SIGNATURE <i>Eugene C. Baumann, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/10/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>CAR LAWN</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Connolly.</i>		ADDRESS <i>413 Eastern Ave. Baltimore 21</i>		24a. REC'D. BY REGISTRAR DATE <i>UNIT</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Connolly.</i>		

RECEIVED  
BUREAU V. S.

UN 11 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05982

5991

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balt. City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN 1b <b>52 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 15</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS <b>2413 Maryland Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Robert</b>		First	Middle	Last	4. DATE OF DEATH <b>June 13 1957</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>3-29-1900</b>	9. AGE (In years lost birthday) <b>57 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Structural Steel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Texas, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles Wm. Cox</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Price</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-577</b>		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  DUE TO		Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  (b) DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>4-22-1957</b> to <b>6-13-1957</b> , that I last saw the deceased alive on <b>June 12, 1957</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>
ACTUAL SIGNATURE <b>William Newcomer</b>								DATE SIGNED <b>6-13-57</b>
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>								
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 17-1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Ch</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank X Detz</b>		ADDRESS <b>814 W. 1 St. Baltimore, Md.</b>		24a. RECEIVED BY REGISTRAR <b>N 17 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Sophy Newell</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

7 1957

REGELIVE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

5938

05983/4  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> Turners Station		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Turners Station</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN 16		d. STREET ADDRESS <i>612 Peach Orchard Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>612 Peach Orchard Lane</i>				4. DATE OF DEATH Davis June 25 1957		Month Day Year	
3. NAME OF DECEASED (Type or print) <i>Beulah</i>		First Middle		Last			
5. SEX Female		6. COLOR OR RACE Col red		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1911	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cook</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Goucher College</i>		11. BIRTHPLACE (State or foreign country) <i>Darlington, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Clarence Hunt</i>				14. MOTHER'S MAIDEN NAME <i>Josephine Hunt</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>[Redacted]</i>		17. INFORMANT <i>Leslie Davis</i>		Address <i>612 Peach Orchard Lane</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Hernia</i> DUE TO <i>Skin</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> ACTUAL SIGNATURE <i>Jack C. Collins</i> DATE SIGNED <i>6 26-57</i> EXAMINER'S NAME (Type) <i>Jack C. Collins</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-28-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Wellsville, Ohio</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i> ADDRESS <i>802 Madison Avenue, Baltimore 1, Maryland</i> JUN 27 1957 REC'D BY REGISTRAR DATE							
24b. REGISTRAR'S SIGNATURE <i>John Flynn</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or to burial, cremation, or removal.

RECEIVED  
BUREAU V.

1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05984

5992

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hood Convalescent Home 5313 Edmondson Avenue		d. STREET ADDRESS 3609 Old York Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Anna	Middle Webb	Last Degenhardt
4. DATE OF DEATH	Month June	Day 25	Year 1957
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 24, 1883
9. AGE (In years last birthday) 74	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
13. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wm. L. Vogle, 373 Evesham Avenue, Baltimore 12		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492.1 DUE TO Cardiac Failure - Chronic Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO ASCVD - marked (c)		INTERVAL BETWEEN ONSET AND DEATH ? yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Previous CVA - Pneumonia	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957, to June 25, 1957, that I last saw the deceased alive on June 25, 1957, and that death occurred at 4:15 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Doctor J. Kug</i> M.D. ADDRESS (Street, city or town, state) Catonsville, Md. DATE SIGNED 6/25/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-27-57	
22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE JUN 27 '57	
		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

RECEIVED  
BUREAU V. S.

1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5993

## CERTIFICATE OF DEATH

059858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ruxton</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7532 Bellona Ave.</b>				d. STREET ADDRESS <b>7532 Bellona Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HELEN</b>		First <b>Helen</b>	Middle <b>R.</b>	Last <b>Denbow</b>	4. DATE OF DEATH <b>June 28,</b>	Month <b>1957</b>	Day <b></b>	Year <b></b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 15, 1914</b>	9. AGE (In years lost birthday) <b>43</b> yrs	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS Days <b></b>	12. IF UNDER 24 HRS Hours <b></b>	13. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. FATHER'S NAME <b>William F. McKewen</b>			
13. FATHER'S NAME <b>William F. McKewen</b>		14. MOTHER'S MAIDEN NAME <b>Helen Roddy</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>David Denbow</b>		Address <b>7532 Bellona Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				<b>Cerebral Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
				<b>Atrial Fibrillation</b>		12 yrs.			
				<b>Rheumatic Heart Disease</b>		30 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>7501 York Rd</b>		20f. (City or town) <b>Baltimore</b>		(County) <b>6/19/57</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Oct 1, 1948</b> to <b>June 28, 1957</b> that I last saw the deceased alive on <b>June 26, 1957</b> , and that death occurred at <b>897</b> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Charles F. O'Donnell</b>		DATE SIGNED <b>6/19/57</b>	
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>									
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral</b>		22d. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas F. Evans &amp; Son</b>		ADDRESS <b>118 W. MT. Royal</b>		24a. REC'D BY REGISTRAR <b>APR 11 1957</b>		24b. REGISTRAR'S SIGNATURE <b>March Gray</b>			

8. V. ZAU

700

REFUGEE

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director for burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05986 37
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Baltimore MARYLAND					b. STATE Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural					c. LENGTH OF STAY IN 1b d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND Training School Boys					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>for</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Chris Z Middle DiMetri					f. STREET ADDRESS 3018 Glenmore Ave					
g. DATE OF DEATH June 25, 1957		h. MONTH Month Day Year		i. IF UNDER 1 YEAR Months Days Hours Min.						
S. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11. BIRTHPLACE (State or foreign country) Baltimore Md.		9. AGE (In years from birthday) 11 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <i>Zaharias</i>		14. MOTHER'S MAIDEN NAME <i>Pavlopoulos</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4359 DUE TO Aspiration of vomitus Conditions, if any, which give rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Struck by lightning		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by lightning						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 6/25/1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Balto.		(County) Balto.		(State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <i>William V. Lovitt</i>										
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-29-57		22c. NAME OF CEMETERY OR CREMATORIAL Greek Cemetery		22d. LOCATION (City, town, or county) Baptist, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Lambros Inc. 440 E North Ave										
VS. A15ME(S) 5M 9/55										

REGGIE VEL  
EAU V. E.

1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05987  
35

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MD</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKTON, MD.</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d. STREET ADDRESS <b>832 W. 34<sup>th</sup> ST.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Eddie Alfred Dix</b>		First	Middle	Last	4. DATE OF DEATH <b>JUNE 15 1957</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/21/20</b>	9. AGE (In years last birthday) <b>36 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GAS + ELECTRIC</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Tandy Dix</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>240 W.W. 168142552</b>		17. INFORMANT <b>EVELYN L. DIX - 832 W. 34<sup>th</sup> ST.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO <b>Crushing injury of chest</b>						
(b)								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile struck concrete culvert—steering wheel crushed chest</b>						
20c. TIME OF INJURY Month, Day, Year Hour <b>6/15/57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>At Highway</b>		20f. (City or town) <b>PARKTON BAPT. MD</b>		(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>A. M. France</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/15/57</b>		
EXAMINER'S NAME (Type) <b>A. M. FRANCE</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/18/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) <b>Windsor Mill Rd. Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Austin G. Donovan - 3818 Polkwood Ave</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 20 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Austin G. Donovan</b>		

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

BUREAU V. L.

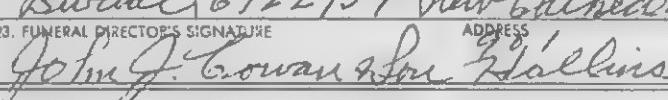
JUN 20 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

115988

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission)						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Length of Stay in lb 402		c. STATE Maryland b. COUNTY						
Catonsville April 1 1957		2 days								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		103 S. Monroe St.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
SPRING GROVE STATE HOSPITAL										
3. NAME OF DECEASED (Type or print)		First Karalina	Middle Helen	Last Drusutis	4. DATE OF DEATH	Month June	Day 18	Year 1957		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown 1961/1226/1881/	9. AGE (In years last birthday) 659 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY housewife		11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? Lithuania				
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Unknown								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-18-0994		17. INFORMANT Mrs. Anna Alvey, 1201 Carroll St., Palto. 30 Records: SPRING GROVE STATE HOSPITAL Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute cardiac failure		INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) Cardiovascular disease								
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Fracture of left femur 5-16-57										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) Pt. fell while getting out of bed on 5-10-57.								
20c. TIME OF INJURY Hour a.m. 9:00		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) Catonsville		(County) Md.		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED 6-18-57
NAME (Type) George M. Kieffer, M. D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/12/57		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Conn		22d. LOCATION (City, town, or county) 4300 Old Frederick Rd.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS John J. Cowan & Son Hollins St		24a. REC'D BY REGISTRAR JUN 20 '57		REGISTRAR'S SIGNATURE John J. Cowan				

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your records.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, nor a burial, cremation, or removal.

VS A15ME(S)  
SM 9/55

BUREAU V. S

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5997

## CERTIFICATE OF DEATH

05989

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY  Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b x2 Overlea		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Overlea				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 509 Old Home Road		d. STREET ADDRESS 509 Old Home Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mrs. Margaret J. Duvall		First	Middle	Last	4. DATE OF DEATH June 17th	Month	Day	Year
5. SEX Female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1878	9. AGE (in years lost/birthday) 78 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Peter Smith		14. MOTHER'S MAIDEN NAME Elizabeth Keeger						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of serv/c)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John Duvall, 509 Old Home Road #6		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Anterior atherosclerotic Cardiovascular Disease						INTERVAL BETWEEN ONSET AND DEATH 8 yrs		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO						
(c)		DUE TO						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple Cerebral Thromboses						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) (State)
21. I certify that I attended the deceased from _____		1949, 19		to June 1957		that I last saw the deceased alive on _____		
actual signature Dr. Loy M. Zimmerman		M.D.		ADDRESS (Street, city or town, state) 3202 Harford Road Baltimore		DATE SIGNED 6/17/57		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/1957		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #18		24a. REC'D BY REGISTRAR DATE 6/18/57		24b. REGISTRAR'S SIGNATURE Mrs. L. L. Jones		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05990

5998

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>		c. LENGTH OF STAY IN 1b <b>41 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>54 Oella Avenue</b>		e. STREET ADDRESS <b>54 Oella Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>MARY HAZEL EDMONSTON</b>		4. DATE OF DEATH <b>June 2, 1957.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>January 18, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Spooler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woolen Factory</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William H. East</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah E. Dailey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>213-09-6347</b>		17. INFORMANT <b>Mrs. Helen Woode</b>	Address <b>54 Oella Avenue Oella, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>440X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Acute Congestive Heart Failure</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		<b>Chronic Degenerative Myocarditis.</b>	
DUE TO <b>Chronic Degenerative Myocarditis.</b>		<b>Generalized Arteriosclerosis.</b>	
(c) <b>with Hypertension.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hemiplegia rt. old</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____		alive on _____	
22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 5, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. John's Cemetery</b>		22d. LOCATION (City, town, or county) <b>Ellicott City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Caston Sons, Catonsville 28, Md.</b>		ADDRESS <b>Catonsville 28, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 6 1957</b>		24b. REGISTRAR'S SIGNATURE <b>L. J. Smith</b>	

BUREAU V. S.

N 6 1957

RECEIVED

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05991

5999

## CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b> Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Catonsville</b>		LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Catonsville</b>	
3. NAME OF DECEASED (Type or Print) <b>GARY</b>		4. DATE OF DEATH <b>Jun 16, 1957</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Dec 7, 1891</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Larkin Fields</b>		14. MOTHER'S MAIDEN NAME <b>Marie Holland</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <b>Mrs. Rosa Fields 52 Winters Ln.</b>		18. MEDICAL CERTIFICATION <i>Hypertension Cardiac Disease 2 yrs Arterosclerosis</i>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause      (a) ... Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last      (b) ...  L...      (c) ...			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jun 30</b> , 1956, to <b>June 16, 1957</b> , that I last saw the deceased alive on <b>June 17, 1957</b> and that death occurred at <b>4</b> p.m., from the causes and on the date stated above. SIGNATURE: <i>John Doe</i> ADDRESS: <b>814 Boyce St Ellicott City MD</b> DATE SIGNED: <b>23/7/57</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>6-20-57</b>	
DATE REC'D BY LOCAL REG.		NAME OF CEMETERY OR CREMATORIUM <b>Western Star Cem.</b>	
REG.		LOCATION (City, town, or county) <b>Catonsville, Md.</b>	
REG.		24. FUNERAL DIRECTOR ADDRESS <b>Mr. George E. Hunter, Jr.</b>	
REG.		REG.	

RECEIVED  
MAY 14 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05992

5939

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician and completely filled in by the attending physician. If institution, Residence before admission should be filed with the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the attending physician, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY E	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b RURAL and give nearest town Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2057 Inverton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  WILLIAM R. FITZELL		4. DATE OF DEATH June 7 19 57	Month Day Year
S SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 3, 1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Improvements		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Richard Fitzell		14. MOTHER'S MAIDEN NAME Emma Lynch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-09-4320 17. INFORMANT Mr. John Richard Fitzell-2057 Inverton Road #22	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 590X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m 19 p.m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-5 1957 to 6-1 1957, that I last saw the deceased alive on 6-1 1957, and that death occurred at 1371 M, from the causes and on the date stated above. ACTUAL SIGNATURE Jack Collins M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) JACK C Collins Baltimore 22. MD DATE SIGNED 6-10-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/57	22c. NAME OF CEMETERY OR CREMATORIUM Oaklawn Cemetery
22d. LOCATION (City, town, or county) Baltimore County, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Fischer & Sons - North & Pa. Ave.		24a. REC'D BY REGISTRAR DATE 6/12/57	24b. REGISTRAR'S SIGNATURE J. J. JONES

BUREAU V. S.

JUN 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your information.

VS. ATSM(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 05993		
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point					c. LENGTH OF STAY IN 1b Sparrows Point Dispensary					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore-16		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sparrows Point Dispensary					d. STREET ADDRESS 2802 Belmont Ave.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Moses	Middle (NMI)	Last Fitzgerald	4. DATE OF DEATH June 19, 1957	Month June	Day 19	Year 1957				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1902		9. AGE (in years, months and days) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Steel plant</b>			11. BIRTHPLACE (State or foreign country) <b>Crewe, Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Pryor Fitzgerald</b>					14. MOTHER'S MAIDEN NAME <b>Martha Oliver</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT <b>Mrs. Addie Fitzgerald</b> Address <b>2802 Belmont Ave.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)										INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Jack E. Collins</i> EXAMINER'S NAME (Type) <i>Jack E. Collins</i>										DATE SIGNED <i>6-19-57</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>23 June 57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arbutus Memorial Pk.</b>			22d. LOCATION (City, town, or county) <b>Baltimore Co., Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Gibson, Jr.</b> ADDRESS <b>1631 Druid Hill Ave.</b>										24a. REC'D. BY REGISTRAR DATE <b>6/19/57</b>		
										24b. REGISTRAR'S SIGNATURE <i>K. L. Smith, Esq.</i>		

BUREAU V. S.

JUN 24 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

Item 2 By phone Wm. Tickner 6-2-7-14

05994

## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN lb 2mths15dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SPRING GROVE STATE HOSPITAL</i>				d. STREET ADDRESS 411 Pontiac St. 15 Maryland Avenue	
3. NAME OF DECEASED (Type or print) <i>Mary Margaretta Fitzjarrell</i>		First	Middle	Last	4. DATE OF DEATH Month Day Year June 19 19 57
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	b. DATE OF BIRTH <i>May 21, 1882</i>	9. AGE (In years last birthday) <i>75</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>occupational therapist</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>George W. Edwards</i>		14. MOTHER'S MAIDEN NAME <i>Adelaide H. Carver</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i>					
DUE TO  (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 25, 1957</u> , to <u>June 19, 1957</u> , that I last saw the deceased alive on <u>June 19, 1957</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>Stella Wachsler</i>		M.D.		SPRING GROVE STATE HOSPITAL 6-19-57	
PHYSICIAN'S NAME (Type) <i>Stella Wachsler, M. D.</i>		Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/22/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Green Mount Cem.</i>	
22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Schuler &amp; Sons - Baltimore</i>		ADDRESS <i>1111 N. Charles St. Baltimore</i>		24a. REC'D BY REGISTRAR DATE <i>June 25 '57</i>	
				24b. REGISTRAR'S SIGNATURE <i>John E. Schuler</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

UN 26 1957

REGELIV ECU

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6902 CERTIFICATE OF DEATH**

05995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore Maryland</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>14 days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Camp Spring, Maryland</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>Andrews Air Force Base</b>				
3. NAME OF DECEASED (Type or print) <b>Etta Mae Chatham</b>		First	Middle	Last	4. DATE OF DEATH <b>June 14</b>	Month	Day	Year <b>19 57</b>
S SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1879</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				
10c. BIRTHPLACE (State or foreign country) <b>Penna.</b>				11. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>John Chatham</b>				14. MOTHER'S MAIDEN NAME <b>Marie Brieb</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>uhknonw</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>								INTERVAL BETWEEN ONSET AND DEATH
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, generalized and severe								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>								19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SPRING GROVE STATE HOSPITAL</b>		(County) <b>6-14-57</b>		(State)
21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>57</b> to <b>June 14</b> , 19 <b>57</b> at <b>SPRING GROVE STATE HOSPITAL</b> 6-14-57 what I last saw the deceased alive on <b>June 14</b> , 19 <b>57</b> , and that death occurred at <b>9:50 a.m.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>		DATE SIGNED <b>6-14-57</b>				
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland						

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-18-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Williamsport, Pa.</b>	22d. LOCATION (City, town, or county) <b>Williamsport, Pa.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. H. Williamsport Pa</b>		ADDRESS <b>Mac Mallison Catonsville Md</b>	24a. REC'D BY REGISTRAR <b>JUN 17 57</b>	24b. REGISTRAR'S SIGNATURE <b>DeLack</b>

BUREAU V.

JUN 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6003

## CERTIFICATE OF DEATH

05996

44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND	2 USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c LENGTH OF STAY IN lb <b>19 Days</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d STREET ADDRESS <b>918 Creek Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>K.</b>	Last <b>FORD</b>	4. DATE OF DEATH Month <b>June</b>	Day <b>19</b>	Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13, 1892</b>	9. AGE (In years from last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings</b>		11. BIRTHPLACE (State or foreign country) <b>Eastport, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Ford</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Davis</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>211-18-2704</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
47IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1. Arteriosclerosis, generalized. 2. Diabetes Mellitus. 3. Cerebral thrombosis, left, old.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>VA</b>	Month <b>19</b>	Day <b>May 31</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) <b>Annapolis National</b>	20f. (City or town) <b>Annapolis</b>	(County) <b>Maryland</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>May 31</b> , 1957, to <b>June 19</b> , 1957.		XX-XXXX-XXXXXX-XXXXXX		and that death occurred at <b>10:40 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <b>Armen Bogosian</b>		M.D.		<b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>6/20/57</b>	
PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-24-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Annapolis National</b>	22d LOCATION (City, town, or county) <b>Annapolis, Maryland</b>			(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Cook-Bright, Inc.</b>		ADDRESS <b>6009 Harford Rd., Balto., Md.</b>	24a REC'D BY REGISTRAR <b>6/21/57</b>	24b REGISTRAR'S SIGNATURE <b>J.W. Cook-Bright, Inc.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JUN 21 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6904

## CERTIFICATE OF DEATH

Reg. Dist. No.

05997

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>242 Blakney Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
3. NAME OF DECEASED (Type or print)	First <b>Anna C Forney</b>	Middle Last	4. DATE OF DEATH Month <b>June 15, 1957</b> Day Year <b>19</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 12, 1871</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Henderson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Considine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212.16.3935-B</b>	
17. INFORMANT <b>Mrs Edna Demarest</b>		Address <b>242 Blakney Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Central accident</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>June</b> Day <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> , to <b>June 15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June 17</b> , 19 <b>57</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Joseph Robert Lister M.D. 8508 Bond St., Baltimore 4, Md.</b>			
PHYSICIAN'S NAME (Type) <b>JOSEPH ROBERT LIBERTI</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/19/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 18 '57</b>
			24b. REGISTRAR'S SIGNATURE <b>Quinton</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.  
JUN 18 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4  
6005

## CERTIFICATE OF DEATH

Reg. Dist. No.

05998

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN lb  
d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

9 Carroll Rd.

3. NAME OF  
DECEASED  
(Type or print)First  
EdnaMiddle  
MarieLast  
Foster4. DATE  
OF  
DEATH  
JuneMonth  
Day  
Year  
5  
1957

## 5. SEX

F.

## 6. COLOR OR RACE

W.

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

## 8. DATE OF BIRTH

Oct. 26, 1896

9. AGE (In years  
lost birthday)60  
yrs10. IF UNDER 1 YEAR  
Months Days11. IF UNDER 24 HRS  
Hours Min.10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

H.W.

## 10b. KIND OF BUSINESS OR INDUSTRY

O.H.

## 11. BIRTHPLACE (State or foreign country)

Balto. Md.

## 12. CITIZEN OF WHAT COUNTRY?

USA

## 13. FATHER'S NAME

James J. Huster

## 14. MOTHER'S MAIDEN NAME

Marie Elizabeth

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

(If yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Mr. August L. Foster, 9 Carroll Rd, Catonsv.

Address

## 18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

Hemorrhage Thrombosis

Arteriosclerotic Cardio-Vascular Disease

INTERVAL BETWEEN  
ONSET AND DEATH

## MEDICAL CERTIFICATION

## Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month Day Year  
Hour a. m. 19 p. m.20d. INJURY OCCURRED  
White Not white  
of work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from April 15, 1957, to May 21, 1957, that I last saw the deceased alive on May 21, 1957, and that death occurred at 4:30 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATUREPHYSICIAN'S  
NAME (Type)

P. C. MacLaughlin, M.D.

M.D. 4508 Edmondson Village

6/6/57

4508 Edmondson Village, Balto. 22, Md.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

June 8/57

## 22c. NAME OF CEMETERY OR CREMATORI

New Cathedral Cem.

## 22d. LOCATION (City, town, or county)

Balto. Md.

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

Witzke Funeral Directors, 4101 Edmondson

## ADDRESS

## 24a. REC'D. BY REGISTRAR

DATE

## 24b. REGISTRAR'S SIGNATURE

'57

RECEIVED  
MAY 20 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6006

## CERTIFICATE OF DEATH

Reg. Dist. No.

059998

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2 USUAL RESIDENCE (Where deceased) <input type="checkbox"/> ved. If institution: Residence before admission a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>3215 Batavia Avenue</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Mrs. Rosa A.</i>	First	Middle	Last		
4. DATE OF DEATH <i>July 23rd, 1957</i>	Month	Day	Year		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 11, 1877</i>		
9. AGE (In years lost day)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Frank Kroeger</i>	14. MOTHER'S MAIDEN NAME <i>Rose</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. William J. Foster, 3215 Batavia Ave.</i>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5716 Belvedale Ave</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Maryland</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>June 23, 1957</i> to <i>June 23, 1957</i> , that I last saw the deceased alive on <i>June 23, 1957</i> , and that death occurred at <i>9:45 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert Mazer</i> PHYSICIAN'S NAME (Type) <i>ROBERT MAZER</i> ADDRESS (Street, city or town, state) <i>Baltimore 18 MD</i> DATE SIGNED <i>6/24/57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6/20/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Moreland Mem Park</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>	ADDRESS <i>5305 Hargord Road #14</i>	24a. REC'D BY REGISTRAR <i>JUN 26 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mazer Guy Jr</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

May 2, 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06000

6007

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oella</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		d. STREET ADDRESS <b>Columbia Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>47 Oella Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>RACHEL ANNA GAMBER</b>		First	Middle	Last	4. DATE OF DEATH <b>June 13</b>	Month	Day	Year <b>19 57</b>	
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> May 30, 1892</b>	9. AGE (In years last birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Eli BeCraft</b>		14. MOTHER'S MAIDEN NAME <b>Ida Wilson</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Erna Delawder, Ellicott City, Md</b>		Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Afternoon - CV disease</i>						INTERVAL BETWEEN ONSET AND DEATH <b>Sign</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO							
{ couse (a), stating the under- lying cause last. (c)}		DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ellicott City, Md.</b>		20f. (City or town) <b>Ellicott City, Md.</b>		(County) <b>Ellicott City, Md.</b>	(State) <b>Ellicott City, Md.</b>
21. I certify that I attended the deceased from <b>June 12, 1957</b> , to <b>June 13, 1957</b> , that I last saw the deceased alive on <b>June 12, 1957</b> , and that death occurred at <b>Ellicott City, Md.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Ellicott City, Md.</b>		DATE SIGNED <b>6-13-57</b>	
ACTUAL SIGNATURE <i>Eli BeCraft</i>									
PHYSICIAN'S NAME (Type) <b>Leon H. Kochman M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-17-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Good Shepherd</b>		22d. LOCATION (City, town, or county) <b>Ellicott City, Md.</b>		(State) <b>Ellicott City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>17 57</b>		24b. REGISTRAR'S SIGNATURE <i>Rehle</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 17 1957

REGELIV ED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6'08

## CERTIFICATE OF DEATH

Reg. Dist. No.

0600 R 82

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>St. Mary's Co.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>3yr 4mths 7days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood, Maryland (Leonardtown)</b>		d. STREET ADDRESS <b>Hollywood, Maryland</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Oster</b>	Middle <b>May</b>	Last <b>Gatton</b>	4. DATE OF DEATH <b>June 19, 1957</b>	Month <b>June</b>	Day <b>19</b>	Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, ??</b>		9. AGE (in years last birthday) <b>68 yrs</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Arteriosclerotic cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Catoctin Chapel Hollywood	20f. (City or town) Hollywood	(County) Maryland	(State) Maryland		
21. I certify that I attended the deceased from <b>Feb. 12, 1956</b> , to <b>JUNE 19, 1957</b> , that I last saw the deceased alive on <b>JUNE 19, 1957</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>								
DATE SIGNED <b>Charles Ward</b>								
ACTUAL SIGNATURE <b>DR. CHARLES WARD</b>								
PHYSICIAN'S NAME (Type) <b>Catoctin Chapel Hollywood</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1957</b>		22c. NAME OF CEMETERY OR Crematory <b>Catoctin Chapel Hollywood</b>		22d. LOCATION (City, town, or county) <b>Hollywood</b>		
(State) <b>Maryland</b>								
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clark Battisby</b>		ADDRESS <b>Fairview, Md.</b>		24a. REC'D BY REGISTRAR <b>John Clegg</b>		24b. REGISTRAR'S SIGNATURE <b>John Clegg</b>		
DATE <b>6/21/57</b>								

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page \_\_\_\_\_ of \_\_\_\_\_ may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y

NY 34 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

6009

## **CERTIFICATE OF DEATH**

06002 /

**Reg. Dist. No**

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE		Md.	
BALTO.				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTO.	
RURAL - ROCKDALE		3 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		RURAL - ROCKDALE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		3610 ROCKDALE TERRACE		d. STREET ADDRESS		3610 ROCKDALE TERRACE	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day Year
JEA		ISABELLE		GIEGAS	6	4	19 57
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min
F	W	1/14/1878		79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWORKS		HOUSEWORK		WEST VIRGINIA		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
CHARLES GIEGAS		AMANDA MILLER					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
		405 NE 111		HRS. MC FARLAND		3610 ROCKDALE TERRACE BALTO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO		CONGESTIVE HEART FAILURE - PULMOVARY ETC.		INTERVAL BETWEEN ONSET AND DEATH 3 MONTHS	
X							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	DUE TO	HYPERTENSION			
		(c)					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Month, Day, Year Hour a. m. p. m.		19					
21. I certify that I attended the deceased from <u>MARCH 19 57</u> to <u>JUNE 4, 1957</u> , that I last saw the deceased alive on <u>JUNE 3, 1957</u> , and that death occurred at <u>8204 LIBERTY RD</u> , M.D., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE <u>Edwin Pierpoint</u>							
PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPOINT</u> <u>8204 LIBERTY RD, BALTO. MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial June 6 '57		1957		West Cemetery		Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Edwin Pierpoint - 8204 Liberty Heights, Balto. MD.</u>				Date JUN 7 1957		1957 by <u>Edwin Pierpoint</u>	

RECEIVED  
JUN 7 1957

BUREAU V.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5945

## CERTIFICATE OF DEATH

06003  
44

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <i>MARYLAND</i> b. COUNTY <i>Arbutus</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Arbutus</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5616 Carville Ave</i>		e. STREET ADDRESS <i>5616 Carville Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Willard E. Gilbert, Sr.</i>		4. DATE OF DEATH <i>June 26/57</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5, 1894</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wending Machine Proprietor, Own Business</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Machine Proprietor, Own Business</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Denton Gilbert</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Wife Mrs. Linda O. Gilbert, 5616 Carville Ave</i>	
17. INFORMANT <i>Mrs. Linda O. Gilbert, 5616 Carville Ave</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>165X</i> DUE TO <i>CARCINOMA LUNG &amp;</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>METASTASIS BRAIN -</i> (b) DUE TO <i>ACUTE PULMONARY EDEMA</i> (c)	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>14</i> , 19 <i>57</i> , to <i>6/26</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>6/26</i> , 19 <i>57</i> , and that death occurred at <i>4:20 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5800 Edmondson Ave.</i> DATE SIGNED <i>John Holman M.D.</i>			
ACTUAL SIGNATURE <i>John Holman</i>		PHYSICIAN'S NAME (Type) <i>John Holman</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 29/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park</i>		22d. LOCATION (City, town, or county) <i>Baltimore, MD</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Directors, 4101 Edmondson</i>		24a. REC'D BY REGISTRAR <i>Ave</i> DATE <i>July 1, 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Dr. Leo M. Kupper</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUL 1 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06004

## 6910 CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
BALTIMORE MARYLAND		BALTIMORE b. COUNTY BALT. CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN Tb Catoonsville	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE, MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove State Hospital	d. STREET ADDRESS 3405 PINKNEY ROAD	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First 55531 Middle GLADOMON Last	4. DATE OF DEATH JUNE 19 1957	Month	Day Year
5. SEX Female COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-45	9. AGE (In years lost birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) BALTIMORE, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Theopholous GLADOMON		14. MOTHER'S MAIDEN NAME Mary ANDERSON Flechner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT		Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 42.1		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV 30, 1956, to JUN 19, 1957, that I last saw the deceased alive on JUN 19, 1957, and that death occurred at 2:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Stella Wachsler M.D. ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 6-19-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1957	
22c. NAME OF CEMETERY OR CREMATORY London Park		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Teufel 5311 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE JUN 24 1957	
		24b. REGISTRAR'S SIGNATURE Ollie Smith	

BUREAU V. S

IN A 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6011 CERTIFICATE OF DEATH

06005  
20

Reg. Dist. No.

M

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	a. STATE	b. COUNTY
Catonsville		16 Mos.	Maryland	Baltimore
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
Paradise Nursing Home, Catonsville				
3. NAME OF DECEASED (Type or print)	First Mary	Middle J	Last Gloster	4. DATE OF DEATH Month June 22 Day 19 Year 57
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 13, 1873	9. AGE (In years less birthday) 84 yr.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ireland
Housekeeper				12. CITIZEN OF WHAT COUNTRY Ireland
13. FATHER'S NAME Thomas		14. MOTHER'S MAIDEN NAME Mary Brosnan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Mary M. Farley, 2518 Wilkens Ave.
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  Myocardial failure INTERVAL BETWEEN ONSET AND DEATH 24 hrs		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO ASCVD, severe	(c) DUE TO Unknown	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 304X		
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto.	(County) (State)
21. I certify that I attended the deceased from 2-17, 1957, to 6-22, 1957, that I last saw the deceased alive on 6-21, 1957, and that death occurred at 10 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE STEPHEN LEG M.D. ADDRESS (Street, city or town, State) 908 Frederick Rd. DATE SIGNED 6-29-57 PHYSICIAN'S NAME (Type) STEPHEN LEG M.D. Caronville 29, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 25/57	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral	22d. LOCATION (City, town, or county) Balto.	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lilly and Zeiler Inc., 403 S. Wolfe St.	ADDRESS	24a. REC'D BY REGISTRAR DATE 6/24/57	24b. REGISTRAR'S SIGNATURE A. H. H. 1/2	

BUREAU V. 8

JUN 25 1962

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06006		
6012 CERTIFICATE OF DEATH										Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN lb <b>1yr8mth26dys</b>		b. COUNTY <b>Pr. Geo.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ritchie, Maryland</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>					d. STREET ADDRESS <b>6501 Darcy Road</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>LYLE</b>	Middle <b>EDWARD</b>	Last <b>GOULD</b>	4. DATE OF DEATH Month June Day 18 Year 19 57							
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 2, 1882</b>		9. AGE (In years last birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Michigan</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>Gilbert Gould</b>					14. MOTHER'S MAIDEN NAME <b>Hannah Root</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>										INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized and severe</b>												
DUE TO (c)												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from <b>April 17, 19 57</b> , to <b>June 10, 19 57</b> , that I last saw the deceased alive on <b>June 10, 19 57</b> , and that death occurred at <b>1:15 p.m.</b> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D.		SPRING GROVE STATE HOSPITAL		<b>6-10-57</b>				DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>						<b>Catonsville 28, Maryland</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>6-13-'57</b>		22b. DATE THEREOF <b>6-13-'57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>U. of Md. Med. School</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Snafey Board</b>		ADDRESS <b>29 S. Greene St.</b>		24a. REC'D BY REGISTRAR <b>6/13/57</b>		24b. REGISTRAR'S SIGNATURE <b>Carlisle</b>						
VS A15 (4) 15M 9/55												

RECEIVED  
BUREAU Y. S.  
JUN 18 1957

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your records.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18, Film 216

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06007

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		d. STREET ADDRESS <b>7925 York Rd.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7925 York Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Avis</b>		First	Middle	Last	4. DATE OF DEATH Month	Month	Doy	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 6, 1881</b>	9. AGE (in years birthday) <b>75</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James T. Quinn</b>		14. MOTHER'S MAIDEN NAME <b>Alice Mary DeLargey</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr., no. or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>James T. Griffin</b>		<i>Address</i> <b>8428 Oakleigh Road Balto. 14, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>33 IX</b> DUE TO <b>Cerebral hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>William V. Lovitt</i>		DATE SIGNED <b>6/12/57</b>							
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 14, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) <b>Pikesville, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns, Son</i>		24a. REC'D BY REGISTRAR <b>Towson, Md.</b> June 18, 1957 24b. REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>							

BUREAU V. S.

JN 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

16008  
30

6914

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 16 <b>5yr4mth27dys</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Howard</b>	Middle <b>Griffith</b>	4. DATE OF DEATH <b>June 16</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 30, 1893</b>		
9. AGE (in years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>restaurant worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>William Griffith</b>			
14. MOTHER'S MAIDEN NAME <b>Penny Singleton</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>			
16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.	Month, Day, Year <b>April 4, 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Catonsville 28, Maryland</b>	20f. (City or town) <b>(County)</b>	(State)
21. I certify that I attended the deceased from <b>April 4, 1957</b> , to <b>June 16, 1957</b> , that I last saw the deceased alive on <b>June 16, 1957</b> , and that death occurred at <b>9:00a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>Stella Wachsler</b> M.D. <b>JUN 24 1957</b>					
ACTUAL SIGNATURE <b>Stella Wachsler</b> M.D. PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b> Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Anatomical Board</b>	22b. DATE THEREOF <b>Unif. mod. ADDRESS</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>295 Greene St</b>	22d. LOCATION (City, town, or county) <b>(State)</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anatomical Board</b>	24a. REC'D BY REGISTRAR DATE <b>6/21/57</b>	24b. REGISTRAR'S SIGNATURE <b>John P. Miller</b>			

BUREAU V. S.

JUN 25 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6015

## CERTIFICATE OF DEATH

06009

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>84 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2340 W. Lexington Street</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ERNEST</b>	Middle <b>S.</b>	Last <b>HAIRSTON</b>	4. DATE OF DEATH <b>June</b>	Month <b>11</b>	Day <b>19</b>	Year <b>57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1898</b>	9. AGE (In years last birthday) <b>59 yrs.</b>	10. IF UNDER 1 YEAR Months <b>59</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>	13. Min <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Ridgeway, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>William Hairston</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Martin</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 230-12-6422</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF STOMACH WITH METASTASES TO</b> <b>X900P ABDOMINAL WALL AND LYMPH NODES</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>VAH, FORT HOWARD, MARYLAND</b>	(County)	(State)				
21. I certify that I attended the deceased from <b>March 19, 1957</b> , to <b>June 11, 1957</b> , and that death occurred at <b>10:50AM</b> , from the causes and on the date stated above.										
ADDRESS (Street, city or town, state)										
ACTUAL SIGNATURE <i>Chien Wei Lan</i> DATE SIGNED <b>6/11/57</b>										
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-14-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State)						
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law Mortuary 802-O, Madison Ave.</b>		ADDRESS <b>Baltimore 1, Md.</b>		24a. REC'D BY REGISTRAR <b>Dawson Farley</b>	24b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 so it can be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUN 17 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached from this certificate and used as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18										06010	Reg. Dist. No. 37	
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Md.</b>					b. COUNTY <b>BALTIMORE CITY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE RURAL</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. WILSON STATE HOSP</b>					d. STREET ADDRESS <b>46 MARKET PLACE</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>JOHN</b>	Middle <b>PHILIP</b>	Last <b>HALE</b>	4. DATE OF DEATH Lost	Month <b>JUNE</b>	Day <b>4</b>	Year <b>1957</b>				
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-11-02</b>	9. AGE (In years lost birthday) <b>54 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>		11. IF UNDER 24 HRS Days <b>0</b>		12. IF UNDER 24 HRS Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARBER</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>BARBERSHOP</b>		11. BIRTHPLACE (State or foreign country) <b>BURWIN, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>JOHN W. HALE</b>					14. MOTHER'S MAIDEN NAME <b>RACHEL SARMAN</b>					Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>					16. SOC AL SECURITY NO <b>197-10-4775</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-22</b> , 19 <b>57</b> , to <b>6-4-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-4-</b> , 19 <b>57</b> , and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>William Newcomer</b> M.D.										DATE SIGNED		
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.												
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>										<b>Mt. Wilson, Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1/57</b>		22c. NAME OF CEMETERY OR Crematory <b>Baltimore City Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank D. Newell</b>					24a. REC'D. BY REGISTRAR ADDRESS <b>Frank D. Newell, Jr., Greenville, Md.</b>		24b. REGISTRAR'S SIGNATURE DATE <b>6-7-57</b>					

BUREAU V. S.

JUN 12 1957

REGEVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06011

Reg. Dist. No.

**PUT MEDICAL EXAM** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO 14</b>		c. LENGTH OF STAY IN 1b <b>15-16 yr</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3022 Texas Avenue</b>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clara</b>		First <b>Clara</b>	Middle <b>Mae</b>
		Last <b>Harris</b>	4. DATE OF DEATH <b>June 9</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 7-1899</b>
9. AGE (In years from birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>As wif-</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Bradley</b>		14. MOTHER'S MAIDEN NAME <b>Bradley née Biddle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>HERBERT DULL 1228 Durst St</b>		Address <b>30</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Generalized Atherosclerosis</b> INTERVA, BETWEEN ONSET AND DEATH <b>1 mme d.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>undet</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John C. Hyde</b>		DATE SIGNED <b>June 9-57</b>	
EXAMINER'S NAME (Type) <b>JOHN C. HYDE</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/12/57</b>	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Road #14</b>		ADDRESS <b>JUN 11 1957</b>	
24a. REC'D BY REGISTRAR <b>R. M. Tracy</b>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

JUN 11 1957

REGELIVE

## 6918 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

06012

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY Baltimore County		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6,		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 6, x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1206 Chesaco Avenue		d. STREET ADDRESS 1206 Chesaco Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First F.	Middle Irene	Last Harrison
4. DATE OF DEATH	Month June	Day 18	Year 19 57
5. SEX Female	6. COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH February 4, 1878.
8 AGE (In years at birthday) 79 yrs		9 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	10 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) Baltimore
			12 CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Tull		14 MOTHER'S MAIDEN NAME Laura Barnett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Laura Lewis, 1206 Chesaco Avenue, Baltimore 6
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 2-2-57	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		2-2-57	
(b) DUE TO Hypertension		2-2-57	
(c) DUE TO Cerebral Hemorrhage		2-2-57	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall down stem at home	
20c. TIME OF INJURY Month, Day, Year Hour — 8 p.m. 2-2-57		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) 1206 Chesaco Ave, Baltimore 6	
(County) MD		(State) MD	
21. I certify that I attended the deceased from June 15, 1957, to June 18, 1957, that I last saw the deceased alive on June 15, 1957, and that death occurred at 8 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 3025 Belair Road	
ACTUAL SIGNATURE William E. Dennis		DATE SIGNED M.D.	
NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6-20-57	
22c. NAME OF CEMETERY OR CREMATORIUM Green Mount Cemetery		22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR PATRICK J. COOK	
		24b. REGISTRAR'S SIGNATURE Asst. L. L. Smith	

BUREAU V. S.

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6919

## CERTIFICATE OF DEATH

06013  
Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After his certificate has been signed by the attending physician and completely filled in, it may be retained by the hospital or attending physician.  
**REGULATOR:** If either of these documents is found to be forged or false, the certificate will be rejected and the funeral director will be fined \$500.00.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>52 Days</b>		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>3240 Westmont Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>CHARLES</b>	Middle <b>R.</b>	Last <b>HAYNES</b>	4. DATE OF DEATH <b>June</b>	Month <b>17</b> Day <b>19</b> Year <b>57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1895</b>	9. AGE (in years from birthday) <b>62</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>62</b> Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cement Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>William S. Haynes</b>		14. MOTHER'S MAIDEN NAME <b>Annie M. Bantown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>216-09-4250</b>		17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>VESTICO-INTESTINAL FISTULA</b>				INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>	
<b>18/1 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO  (b) <b>CARCINOMA OF URINARY BLADDER</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 MONTHS</b>	
DUE TO  (c)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Doy. Year Hour e. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, FORT HOWARD, MARYLAND</b>	
20f. (City or town) <b>VAH, FORT HOWARD, MARYLAND</b>		(County)		(State)	
21. I certify that I attended the deceased from <b>April 26, 1957</b> , to <b>June 17, 1957</b> , and that death occurred at <b>1:05 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Elroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.</b>		DATE SIGNED <b>6/17/57</b>	
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Elroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.</b>	
VS AIS 9 (4) 15M 9/55		DATE <b>6/17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Elroy O. Wilson, 1000 Brantley Ave., Baltimore, Md.</b>	

BUREAU V. S.

JUN 24 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6/20

## CERTIFICATE OF DEATH

06014

Reg. Dist. No.

38

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN lb <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Parkville</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1730 Wycliffe Road</i>		d. STREET ADDRESS <i>1730 Wycliffe Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Mr. Raymond B.</i>		First	Middle	Last	4. DATE OF DEATH <i>Hazelip</i>	Month	Day	Year
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 25, 1894</i>	9. AGE (In years last birthday yrs <i>83</i> )	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>	IF UNDER 24 HRS. Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>D.S.&amp;D. Super-Used Cars-</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Edwin C. Hazelip</i>		14. MOTHER'S MAIDEN NAME <i>Margaret ?</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Ida Mae Hazelip, 1730 Wycliffe Rd.</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Conway Thrombosis -</i>						INTERVAL BETWEEN ONSET, AND DEATH <i>47 p.</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Gastrointestinal Arterosclerosis</i>		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertension</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>6/13/57</i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>6/13/57 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6/13/57</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>None</i> (State) <i>Maryland</i>
21. I certify that I attended the deceased from olive on <i>6/13/57</i> , and that death occurred on <i>6/13/57</i> , at <i>1:30 PM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>10168 East Avenue</i>		DATE SIGNED <i>6/13/57</i>
ACTUAL SIGNATURE <i>Mitchell F. Runkowski</i>								
PHYSICIAN'S NAME (Type) <i>Mitchell F. Runkowski</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/15/57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Hargford Road #14</i>		24a. REC'D BY REG STAR DATE <i>6/13/57</i>		24b. REG STAR'S SIGNATURE <i>6/13/57</i>		

**RECEIVED**

JUN 13 1957

**BUREAU V.**

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

06015

6021

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Baltimore</i>				a. STATE <i>Md.</i>	b. COUNTY <i>—</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Catoonsville</i>		<i>34 yrs</i>		<i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Spring Grove State Hosp.</i>					
3. NAME OF DECEASED (Type or print)	First <i>Laura</i>	Middle <i>—</i>	4. DATE DEATH	Month <i>June</i>	Day <i>2</i> Year <i>1957</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>Widow</i> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-23-73</i>	9. AGE (in years last birthday) <i>84 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Housewife</i>				<i>Connecticut</i>	
13. FATHER'S NAME <i>Joseph W. Phelps</i>		14. MOTHER'S MAIDEN NAME <i>Maggie Wesley</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Wiley Heaps (deceased)</i>	
No				Address <i>New York, NY</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>					
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Arteriosclerosis of heart arteries</i> many years					
DUE TO (c) <i>Generalized arteriosclerosis</i> many years					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? Sociopathic reaction paranoid type chronic YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, or item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p.m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from Sept. 1, 1957, to June 2, 1957, that I last saw the deceased alive on June 2, 1957, and that death occurred at 6:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>William N. Karm Jr.</i> M.D. ADDRESS (Street, city or town, state) <i>Spring Grove State Hosp.</i> DATE SIGNED <i>6-2-57</i>					
22a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		22b. DATE THEREOF <i>6-4-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>AYRES CHAPEL</i>	
22d. LOCATION (City, town, or county) <i>WHITE HALL HARFORD Co., Md.</i>		(State) <i>—</i>		24a. REC'D BY REGISTRAR <i>John G. Johnson</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennell &amp; Blakem Stewart &amp; Son Pa.</i>		ADDRESS <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>John G. Johnson</i>	
VS A15 (4) 15M 9/55		DATE <i>JUN 6 '57</i>			

BUREAU V. S

NY 6 125

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06016

6/22

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard	c. LENGTH OF STAY IN lb 20 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 1513 Ellamont Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First RAYMOND	Middle NMI	Last HENDERSON
4. DATE OF DEATH	Month June	Day 29	Year 19 57
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/26/15
9. AGE (In years lost birthday) 41 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Chemical Company	
10c. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDD HENDERSON		14. MOTHER'S MAIDEN NAME MARY J. JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWII 252-18-9685	
17. INFORMANT Clin.Rec.Vets.Admin.Hospital,Ft.Howard,Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AZOTEMIA DUE TO XOXKOKX		INTERVAL BETWEEN ONSET AND DEATH 3 / weeks	
Conditions if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO GLOMERULONEPHRITIS CHRONIC (c)		3 / weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive cardio vascular disease secondary to #1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18] 44	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 9, 1957, to June 29, 1957, and that death occurred at 12:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>S. Q. Arce</i>		M.D. Veterans Administration Hospital	
PHYSICIAN'S NAME (Type) S. Q. ARCE, M. D.		Fort Howard, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF July 3, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law 802 Madison Ave</i>		ADDRESS 2	24a. REC'D BY REGISTRAR 1957
		24b. REGISTRAR'S SIGNATURE <i>Lawson L. Parker</i>	

REVUE V. E

1957

REVUE V. E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

0716144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 935 West Saratoga Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOSEPH		First	Middle W.	Lost	HENSON	4. DATE OF DEATH June 27	Month Day Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 24, 1896		9. AGE (In years old birthday) 58 yrs.	10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Public building		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Tobias Henson		14. MOTHER'S MAIDEN NAME Charlotte Goodrich						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) Yes		16. SOCIAL SECURITY NO WW I		17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CARCINOMATOSIS, PRIMARY SITE UNDETERMINED INTERVAL BETWEEN ONSET AND DEATH UNKNOWN						
17. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from June 19, 1957, to June 27, 1957, and that death occurred at 10:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state)								
ACTUAL SIGNATURE 		M.D.		VAH, FORT HOWARD, MARYLAND			DATE SIGNED 6/28/57	
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-57		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Annapolis, National		22d. LOCATION (City, town, or county) Annapolis, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Rees, 108 W. Washington St., Annapolis, Md.				24a. REC'D. BY REGISTRAR 1957		24b. REG. STRR'S SIGNATURE Dawson L. Farley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 6 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6 : 6924 CERTIFICATE OF DEATH

06017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Baltimore MARYLAND		Maryland Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16 Catoonsville 2 mont, 28 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INST. TUTION		e. IS RESIDENCE ON A FARM? Spring Grove State hospital	
3. NAME OF DECEASED (Type or print)		First	Middle
Barbara Marie			Higdon
4. DATE OF DEATH		Month	Day
July 1, 1896		June	5
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
Female white			
8. DATE OF BIRTH		9. AGE (In years last birthday) 60 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Seamstress		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		Balto, Md. U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Leopold		Charles Higdon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tot. no. or unknown)		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH (Months)	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive heart failure	
442 v DUE TO		hypertensive cardiovascular disease ?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO	
{		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 8, 1957, to June 5 <sup>th</sup> , 1957, that I last saw the deceased alive on June 5 <sup>th</sup> , 1957, and that death occurred at 11:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE CHARLES WARD, M.D.		ADDRESS (Street, city or town, state) Spring Grove Hosp. - 6/3/57 Catoonsville 28-7000	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 8/57	
22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.		22d. LOCATION (City, town, or county) Balto, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H.H. Witke 4101 EDMONDSON AVE BALT. MD.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE JUN 7 '57	
		24b. REGISTRAR'S SIGNATURE M. B. Edwards	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

ALL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUN 19 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06018

## 6025 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6mths 27dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair, Maryland	
3. NAME OF DECEASED (Type or print) First Mary Middle Susan Last Hines		d. STREET ADDRESS 408 Main Street	
4. DATE OF DEATH June 17		Month	Day Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1874
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (State or Foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ralph Woodward		14. MOTHER'S MAIDEN NAME Manda Lancey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Lung abscess and pneumonia	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterioscler. cardiac disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 6, 1957, to June 17, 1957, that I last saw the deceased alive on June 17, 1957, and that death occurred at 3:40 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 6-17-57	
ACTUAL SIGNATURE Stella Wachsler		PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/19/57	
22c. NAME OF CEMETERY OR CREMATORIUM Mt ZION CEMETERY		22d. LOCATION (City, town, or county) Fountain Green, Harford Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster Broadway & Wallace Street Bel Air, Maryland		24a. REC'D BY REGISTRAR DATE JUN 20 57	
		24b. REGISTRAR'S SIGNATURE Alt. ed.	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

**NO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6026

## CERTIFICATE OF DEATH

06019

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oella</i>		c. LENGTH OF STAY IN lb <i>1b</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>102 Oella Ave</i>		e. STREET ADDRESS <i>102 Oella Ave</i>	
3. NAME OF DECEASED (Type or print) <i>EUGENE EDGAR</i>		First <i>EDGAR</i>	Middle <i>HOBSON</i>
4. DATE OF DEATH <i>6/29/57</i>		Month <i>6</i>	Day <i>29</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Aug. 6, 1888</i>		9. AGE (in years at death) <i>68</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>6</i>
11a. USUAL OCCUPAT. ON (Give kind of work done during most of working life, even if retired) <i>Weaver</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Shoe mill</i>	11c. BIRTHPLACE (State or foreign country) <i>Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>John Hobson</i>		14. MOTHER'S MAIDEN NAME <i>Reese</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>162-2-1234</i>	
17. INFORMANT <i>Margaret Buffington</i>		Address <i>1415 W. 36th St., Baltimore, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumocystic pneumonia left lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>7 mo</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Ellicott City</i>		20f. (City or town) (County) (State) <i>Howard Co. Md.</i>	
21. I certify that I attended the deceased from <i>3-16</i> , 1957, to <i>6-28</i> , 1957, that I last saw the deceased alive on <i>6-28</i> , 1957, and that death occurred at <i>9:00 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>George E. Buffington</i> M.D. ADDRESS (Street, city or town, state) <i>Ellicott City</i> DATE SIGNED <i>6-30-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>7/2/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. John</i>		22d. LOCATION (City, town, or county) <i>Howard Co</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McNabb &amp; Son</i>		24a. REC'D BY REGISTRAR DATE JUL 3 '57	
ADDRESS <i>28</i>		24b. REGISTRAR'S SIGNATURE <i>Albrecht</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LAU V. 9

3 1957



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06920

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN 1b		a. STATE <b>Maryland</b> b. COUNTY				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7826 Shephard Avenue</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
3. NAME OF DECEASED (Type or print) <b>Mr. Joseph H.</b>		First	Middle	Last	4. DATE OF DEATH <b>Hoeck</b>	Month	Day	Year
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1884</b>	9. AGE (In years lost birthday) <b>72 yrs</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Commercial Artist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John J. Hoeck</b>		14. MOTHER'S MAIDEN NAME <b>Mary J. Engel</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>214-14-7033</b>		17. INFORMANT <b>Mrs. Katherine M. Hoeck, 1320 E. Belvedere Avenue</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>02.7X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO <b>Generalized congestive failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>				
		DUE TO <b>Ischaemic Cardiovascular Disease</b>				<b>years</b>		
19. MEDICAL CERTIFICATION <b>115-2</b>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis</b>				21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6014 Loch Raven Blvd.</b>		20f. (City or town) <b>Baltimore</b>		(County) <b>12. Md.</b> (State)
21. I certify that I attended the deceased from <b>March</b> , 19 <b>55</b> , to <b>June</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>June</b> , 19 <b>57</b> , and that death occurred at <b>3:00</b> P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>6014 Loch Raven Blvd.</b>		DATE SIGNED <b>0/6/57</b>
ACTUAL SIGNATURE <b>JF Palmisano</b>		PHYSICIAN'S NAME (Type) <b>Dr. Joseph F. Palmisano</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Mem Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>DATE 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Attn: O. M. T. Corp.</b>		

RECEIVED  
BUREAU V. S.

UN 15 1967

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6028

## CERTIFICATE OF DEATH

060217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d. STREET ADDRESS <b>8545 PULASKI HIGHWAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>Doss</b>	Last <b>HOLDREN</b>	4. DATE OF DEATH	Month <b>6</b>	Day <b>8</b>	Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-10-1900</b>	9. AGE (In years last birthday) <b>57 yrs.</b>	10. IF UNDER 1 YEAR Months <b>5</b>	11. IF UNDER 24 HRS Days <b>7</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE HELPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RUBBER</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE WILLIAM HOLDRЕН</b>		14. MOTHER'S MAIDEN NAME <b>MAE ABBOTT</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>231-16-2547</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF EPICLOTTIS</b> DUE TO <b>161X</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>PULMONARY TUBERCULOSIS.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>CHAMBERSBURG, VA.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-9-1957</b> to <b>6-7-1957</b> , that I last saw the deceased alive on <b>6-7-1957</b> , and that death occurred at <b>4 A.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>6-8-57</b>	
ACTUAL SIGNATURE <b>William Newcomer</b>		M.D. Mt. Wilson, Maryland					
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>6/11/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>FERRY'S CHAP. CHURCH</b>		22d. LOCATION (City, town, or county) (State) <b>CHAMBERSBURG, VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Broderick Bradley</b>		ADDRESS <b>DeMolay #1126</b>		24a. REC'D BY REGISTRAR <b>DATE 6/11/57</b>		24b. REGISTRAR'S SIGNATURE <b>Healthy Newcomer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 &amp; 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUN 11 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06022

## 6029 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
c. LENGTH OF STAY IN 1b <b>Life</b>		d. STREET ADDRESS <b>504 Academy Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>504 Academy Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>W. Howard</b>		First <b>W.</b>	Middle <b>Howard</b>
4. DATE OF DEATH <b>Horton</b>		Month <b>June</b>	Day <b>27</b>
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Feb. 13, 1887</b>		9. AGE (in years last birthday) <b>70</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk, City Of Baltimore</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland.</b>	
10c. BIRTHPLACE (State or foreign country) <b>Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Horton</b>		14. MOTHER'S MAIDEN NAME <b>Emma</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <b>217-01-3710A. Mrs Katherine Horton, 504 Academy Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>651 N Guntower</b>		20f. (City or town) (County) (State) <b>Baltimore</b>	
21. I certify that I attended the deceased from <b>6/1/57</b> to <b>6/27/57</b> , that I last saw the deceased alive on <b>6/27/57</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. J. Mendelis</b>		ADDRESS (Street, city or town, state) <b>Baltimore Md.</b>	
PHYSICIAN'S NAME (Type) <b>C. J. Mendelis M.D.</b>		DATE SIGNED <b>6/28/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jul. 1/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>New Cathedral Cemetery, Balto. Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Dir. 4101 Edmondson Ave</b>		24a. REC'D BY REGISTRAR <b>Jul 1 '57</b>	
		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

RECEIVED  
LIBRARY  
UNIVERSITY OF TORONTO LIBRARIES

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6/30

## CERTIFICATE OF DEATH

06023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Pr. Geo. Co.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr 7mth 14dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Maryland</b>		d. STREET ADDRESS <b>7403 Dartmouth Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>William</b>	Middle <b>H.</b>	Last <b>Hottel</b>	4. DATE OF DEATH	Month <b>June</b>	Day <b>9</b>	Year <b>19 57</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 10, 1881</b>	9. AGE (In years last birthday) <b>75</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newspaperman</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13. FATHER'S NAME <b>John Hottel</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>579-01-7848</b>		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arterioscler. Cardio Vasc. Disease				INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Arteriosclerosis, severe						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. n. p. m.	Month <b>April</b>	Day <b>22</b>	Year <b>1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SPRING GROVE STATE HOSPITAL</b>	20f. (City or town) <b>Colmar Manor</b>	(County) <b>Md.</b>	
21. I certify that I attended the deceased from <b>April 22, 1957</b> , to <b>June 9, 1957</b> , that I last saw the deceased alive on <b>June 9, 1957</b> , and that death occurred at <b>11:45</b> M, from the causes and on the date stated above.						DATE SIGNED		
ACTUAL SIGNATURE <i>Stella Wachler</i>		PHYSICIAN'S NAME (Type) <b>STELLA WACHLER</b>		ADDRESS (Street, city or town, state) <b>Patonsville 28, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>6/11/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or county) <b>Colmar Manor, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 12 '57</b>		24b. REGISTRAR'S SIGNATURE <i>W. L. Beouch</i>		

RECEIVED  
BUREAU N.Y.

JUN 12 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6/31 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06024

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2mths4dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1533 Covington St.</b>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <b>First William Edward Howard</b>		Last <b>Howard</b>		4. DATE OF DEATH Month June Day 16 Year 19 57									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 1, 1906</b>		9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>rigger</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>William Edward Howard, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Birdie Betson</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status convulsivus</b>													
443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Cerebral hemorrhage</b>													
DUE TO (c) <b>Hypertensive cardiovascular disease</b>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
Laennec's cirrhosis of liver													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
ACTUAL SIGNATURE <i>George M. Kieffer</i>								DATE SIGNED <b>6-17-57</b>					
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>								M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 6-20-57</b>		22b. DATE THEREOF <b>6-20-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Saints Cross</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mr. George Steuart Howard</i>		ADDRESS <b>1533 Covington St.</b>		24a. REC'D AT REGISTRY DATE <b>SUN 19 1957</b>		24b. REGISTRY'S SIGNATURE <i>Aut. record</i>							

BUREAU Y. S.

JUN 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6/32 CERTIFICATE OF DEATH

06925

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yrl0mth16dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1232 Patapsco Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Regina</b>	Middle <b>Schiieve</b>	Last <b>Hubschmann</b>	4. DATE OF DEATH <b>June 10</b>	Month <b>June</b>	Day <b>10</b>	Year <b>19 57</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>August 11, 1882</b>	9. AGE (In years last birthday) <b>74</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Schieve</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Gregg</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) <b>nc</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Arteriosclerotic cardiovascular disease</b>						INTERVAL BETWEEN ONSET AND DEATH	
		(b) DUE TO <b>Generalized arteriosclerosis</b>					
		(c) DUE TO <b>Arteriosclerotic cardiovascular disease</b>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>422.1</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SPRING GROVE STATE HOSPITAL</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15</b> , 19 <b>56</b> , to <b>June 10</b> , 19 <b>57</b> at last saw the deceased alive on <b>June 10</b> , 19 <b>57</b> , and that death occurred at <b>2:00a</b> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D.				DATE SIGNED <b>6-10-57</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>				CATONSVILLE 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/13/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Cross Cemetery</b>		22d. LOCATION (City, town, or county) <b>Ritchie Highway Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Brown &amp; Son</b>		ADDRESS <b>90 Hollins St.</b>		24a. REC'D BY REGISTRAR <b>DATUM 12 57</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Brown &amp; Son</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X 5

JUN 12 1957

REFEI V ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5940 CERTIFICATE OF DEATH

06026 41

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		b. COUNTY <b>BALTO.</b>		
c. LENGTH OF STAY IN 1b <b>34 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 DUNDALK (22)</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>221 COLGATE AVE.</b>		d. STREET ADDRESS <b>1021 COLGATE AVE</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ELLEN</b>	Middle <b>TILLEY</b>	Last <b>HYDE</b>	
4. DATE OF DEATH	Month <b>6 - 28 -</b>	Day <b>1957</b>	Year	
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 14, 1874</b>	
9. AGE (In years last birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 24 HRS. Days <b>21</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>JOSEPH TILLEY</b>	14. MOTHER'S MAIDEN NAME <b>SARAH COLE</b>	Address <b>(SAME)</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>BENJ. HYDE</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  (b)  DUE TO  (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <b>chronic nephritis - arteriosclerotic</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)  <b>chronic nephritis - arteriosclerotic</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1956</b> , to <b>June 28, 1957</b> , that I last saw the deceased alive on <b>June 28, 1957</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>ADDRESS</b> ACTUAL SIGNATURE <b>HOWARD BURNS</b> M.D.	DATE SIGNED <b>6/29/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>7/2/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>OAK LAWN</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Alfred Ruth Brooks, Dundalk, Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>8 1957</b>	24b. REGISTRAR'S SIGNATURE <b>J. M. Relley</b>	

HOSPITAL  HOMING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BLAISEAU V. S.

O 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06027

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>—</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bay Shore - Sp Pt - 19</b>		c. LENGTH OF STAY IN 1b <b>—</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b>	
d. STREET ADDRESS <b>2112 E. Pratt St</b>		d. DATE OF DEATH <b>JUNE 17 1957</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>BURL</b>	Middle <b>m.</b>	Last <b>Hyer</b>
4. SEX <b>M</b>	5. COLOR OR RACE <b>Wh. Te</b>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>Nov. 19, 1929</b>
8. AGE (In years last birthday) <b>28 yrs.</b>	9. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	10. IF UNDER 24 HRS. Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Washer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fiskay, Inc.</b>	11. BIRTHPLACE (State or foreign country) <b>A.I.D.</b>
12. CITIZEN OF WHAT COUNTRY? <b>C.I.T.H.</b>		13. FATHER'S NAME <b>Harry C.C. Hyer</b>	
14. MOTHER'S MAIDEN NAME <b>Julia E. Perrine</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>271-32-000</b>		17. INFORMANT <b>Arthur B. Hyer 2112 E. Pratt St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>439.8</b>		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>		DUE TO <b>DROWNING</b>	
DUE TO <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stepped in hole while swimming off Bay Shore</b>	
20c. TIME OF INJURY Month, Day, Year <b>6-17 1957</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>at Bay Nr. Bay Shore Sp. Pt. 19 Bath Md</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>—</b> (County) <b>—</b> (State) <b>—</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B Davis</b>		DATE SIGNED <b>6/17/57</b>	
EXAMINER'S NAME (Type) <b>M.B. DAVIS MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Harrison Cemetery</b>		22d. LOCATION (City, town, or county) <b>Richmond, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John L. Gilliland, Funeral Director</b>		24a. ADDRESS <b>111 W. Main Street, Richmond, Va.</b>	
24b. REC'D BY REGISTRAR <b>24 JUN 1957</b>		24c. REGISTRAR'S SIGNATURE <b>Lawson L. Fisher</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please cut the cert. filete, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Ch. of Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. File Pages 1 and 2 with the registrar or to burial, cremation, or removal.

BUREAU V. S.

NY 5-1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6034

## CERTIFICATE OF DEATH

06028

38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore 18 3VC1-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Armacost Nursing Home 812 Register Avenue		d. STREET ADDRESS		1521 Argonne Drive		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First Freda	Middle C.	Last Irwin	4. DATE OF DEATH	Month June	Day 8	Year 1957
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1886		9. AGE (in years at birthday) 70 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Specht		14. MOTHER'S MAIDEN NAME Sophia (unknown)						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address John S. Irwin, 1521 Argonne Drive		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Myeloma</i>						INTERVAL BETWEEN ONSET AND DEATH 1 yr. ?		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) } DUE TO } (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Anterosclerotic Cardio-Vascular Disease</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 3202 Hartford Rd.		(County) Baltimore, Md.
(State) Md.								(State) Md.
21. I certify that I attended the deceased from <u>Mar.</u> , 1957 to <u>June</u> , 1957, that I last saw the deceased alive on <u>June 7</u> , 1957, and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Loy M. Zimmerman, M.D.</i>				ADDRESS (Street, city or town, state) 3202 Hartford Rd.		DATE SIGNED June 10, 1957		
PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-11-57		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md.		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 12 1957		24b. REGISTRAR'S SIGNATURE <i>Dale E. King</i>		

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, to funeral director, should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 12 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06029

6035

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 so as to be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>		c. LENGTH OF STAY IN 1b <b>32 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2725 Hudson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JANUCHOWSKI First JOHN</b>		MATERIAL F. <b>Do Martin</b> lost <b>JANUHOSKI</b>		4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/24/85</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Motorman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Transit Company</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pete Jamuhoski</b>		14. MOTHER'S MAIDEN NAME <b>Januchowski</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>SAW</b>	
				17. INFORMANT <b>Clin Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last <b>151 X</b>		(b) <b>GASTRIC CARCINOMA</b>				UNKNOWN	
DUE TO <b>Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, Fort Howard, Maryland</b>		(County) <b>M.D.</b> (State)	
21. I certify that I attended the deceased from <b>May 15</b> , 1957, to <b>June 16</b> , 1957, <b>XXXXXX</b>						ADDRESS (Street, city or town, state) <b>VAH, Fort Howard, Maryland</b>	
ACTUAL SIGNATURE <i>[Signature]</i>						DATE SIGNED <b>6/16/57</b>	
PHYSICIAN'S NAME (Type) <b>GARFIELD D. KINGTON, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>JUNE 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Weber Funeral Home, 401 S. Chester St.</b>		ADDRESS <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>6/16/57</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

RECEIVED  
BUREAU X

JUN 19 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06030

Reg. Dist. No.

6936

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar, or to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>				c. LENGTH OF STAY IN lb d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore #17</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>918 N. Gilmore Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>HENRY</b>	Last <b>JOHNSON</b>	4. DATE OF DEATH <b>June 14, 1957</b>	Month <b>June</b>	Day <b>14</b>	Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/23</b>	9. AGE (in years last birthday) <b>34</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during last 5 years of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		14. BIRTHPLACE (State or foreign country) <b>N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>RICHARD Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Gussanna Neville</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Annie M Johnson 918 Cherry Hill Rd.</b>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrocution</b>									
DUE TO Conditions, if any, which gave rise to immediate cause (b)									
DUE TO (a), stating the underlying cause lost. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Electrocuted while at work.</b>							
20c. TIME OF INJURY Hour <b>11:00 P.M.</b>		Month, Day, Year <b>6/14/57</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Factory</b>		20f. (City or town) <b>Baltimore</b>	(County) <b>Md.</b>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		DATE SIGNED <b>6/14/57</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Reburial</b>		22b. DATE THEREOF <b>6/20/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Springfield Church</b>		22d. LOCATION (City, town, or county) <b>Lidaltimore - N.C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall P. Hege</b>		ADDRESS <b>678 N. Gilmore St.</b>		24a. REC'D BY REGISTRAR <b>DATE 17 1957</b>		24b. REG STRAR'S SIGNATURE <b>Garrison &amp; Garrison</b>			
VS. AISMES(S) SM 9/55									

BUREAU Y.

M 17 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

0603133

Reg. Dist. No.

6037

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Reisterstown</b>		d. STREET ADDRESS <b>43 Bond Ave.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>43 Bond Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>SARAH</b>	Middle <b>ELIZABETH</b>	Last <b>JONES</b>	4. DATE OF DEATH	Month <b>June</b>	Day <b>6,</b>	Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>April 29, 1887</b>	9. AGE (In years last birthday) <b>70 yrs</b>	FUNDER 1 YEAR IF UNDER 24 HRS Months <b>70</b>	Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>A.A.Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>***** Samuel Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Fletcher</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Daisy Lee</b>		Address <b>43 Bond Ave Reisterstown Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
b. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<b>Hypertension</b>						
c. DUE TO <b>Arteriosclerosis</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>COX</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Lansdowne</b>	(County) <b>Md.</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>June 3, 1957</b> to <b>June 6, 1957</b> that I last saw the deceased alive on <b>June 6, 1957</b> , and that death occurred at <b>8:50 A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Clarence E. McWilliams</b>	ADDRESS (Street, city or town, note) <b>Reisterstown, Maryland June 6, 1957</b>						DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Clarence E. McWilliams</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/10/1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Zion Cem.</b>	22d. LOCATION (City, town, or county) <b>Lansdowne</b>	(State) <b>Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. Katie R. Williams</b>	ADDRESS <b>322 N. Schroeder St.</b>	24a. REC'D BY REGISTRAR <b>6/10/1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mary G. Lee</b>					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

APR 11 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6038

## CERTIFICATE OF DEATH

06032  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 2mths10days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3341 Windsor Avenue	
3. NAME OF DECEASED (Type or print)	First Mae	Middle J.	Last Knell
4. DATE OF DEATH June 14,	Month	Day	Year 19 57
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or Foreign country) Maryland
13. FATHER'S NAME Andrew Knell, Jr.		14. MOTHER'S MAIDEN NAME Mary J. Roume	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unkncwn	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		Pneumonia Arteriosclerotic cardiovascular disease Generalized arteriosclerosis	
		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 422.3	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 4, 1957, to June 14, 1957, that I last saw the deceased alive on June 14, 1957, and that death occurred at 1:15 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL DATE SIGNED 6-14-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/17/57	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.	22d. LOCATION (City, town, or county) Balto., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE H. M. J. Vickner & Sons - Baltimore		ADDRESS DAHM 17 57	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE D. J. L. 14-14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.  
RECEIVED  
JUN 16 1957

6039 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06033  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - Hamilton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>4102 Hamilton Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>HARRY</b>	Middle <b>CLIFTON</b>	Last <b>KNOPP</b>
4. DATE OF DEATH	Month <b>June</b>	Day <b>26</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/8/1938</b>
9. AGE (In years last birthday) <b>19 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Electric Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? Address	
13. FATHER'S NAME <b>Harry C. Knopp</b>		14. MOTHER'S MAIDEN NAME <b>Catherine M. Bartenfelter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>216-36-4552</b>	17. INFORMANT <b>Catherine M. Knopp 4102 Hamilton Ave</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
DUE TO			
DUE TO			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Found drowned</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>3</b> p.m. 6/22 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Beaver Dam</b>
20f. (City or town) <b>Baltimore</b>		(County) <b>Md.</b>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Russell S. Fisher</i>	DATE SIGNED <b>6/27/57</b>		
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>	M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/29/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clarence F. Hoffman 3218 Hudson St</i>		24a. REC'D BY REGISTRAR <b>JUN 28 '57</b>	
		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, and 3 with the registrar, or removal.

REAU V. S.

11 - 1557

REGIELE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06034

6040

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b>		b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. LENGTH OF STAY IN 16 <b>ESSEX</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		d. STREET ADDRESS <b>714 Maryland Ave</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>714 Maryland Ave</b>				d. STREET ADDRESS <b>714 Maryland Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Fannie</b>		First	Middle	lost	4. DATE OF DEATH <b>June 11 1957</b>	Month	Day	Year	
S SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-29-1898</b>		9. AGE (In years lost birthday) yrs. <b>58</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>? Novak</b>		14. MOTHER'S MAIDEN NAME <b>Julia Borgart</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>[If yes, give war or dates of service]</b>		17. INFORMANT <b>Louis J. Kotroco</b>		Address <b>Same</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema, most acute</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 minutes</b>									
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) <b>Heart failure, acute, backward</b> - <b>cause</b> } DUE TO (c) <b>Hypertensive C.V.D &amp; heart failure, chronic</b> <b>(45 minutes)</b> <b>Second year</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m.      p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>		(County) <b>Baltimore Co.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>September 6, 1956</b> to <b>June 11, 1957</b> , that I last saw the deceased alive on <b>June 11, 1957</b> , and that death occurred at <b>0730 AM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Eugene C. Baumann</b>		DATE SIGNED <b>6-12-57</b>							
PHYSICIAN'S NAME (Type) <b>Eugene C. Baumann, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/13/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn Cemetery</b>		22d. LOCATION (C. b. town, or county) <b>Balto. Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Christine Brzozowski</b>		ADDRESS <b>1407 Eastern Ave</b>		24a. REG'D. BY REGISTRAR DATE <b>13-1957</b>		24b. REGISTRAR'S SIGNATURE <b>C. Baumann</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. 8

JUN 13 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6841

## CERTIFICATE OF DEATH

06035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>149 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2 E. Biddle Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>DAVID</b>	Middle <b>(NMI)</b>	Last <b>LAMONT</b>	4. DATE OF DEATH <b>June 2 1957</b>	Month Year	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/96</b>	9. AGE (In years lost birthday) <b>61 yrs</b>	IF UNDER 1 YEAR Months <b>61</b>	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drydock</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alexander Lamont</b>				14. MOTHER'S MAIDEN NAME <b>Mary Glen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>WVI 107-05-3191</b>		17. INFORMANT <b>Clin. Recs. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF LARGE BOWEL WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>TO PERINEUM</b> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 4, 1957</b> to <b>June 2, 1957</b> , from the causes and on the date stated above. and that death occurred at <b>1:35 A.M.</b> ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>J. A. Baranowski, M.D.</i> DATE SIGNED <b>6/2/57</b> NAME (Type) <b>J. A. BARANOWSKI, M. D.</b> Veterans Administration Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-4-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGinn Funeral Home</b>		ADDRESS <b>130 E. Fort Ave.</b>		24a. REC'D BY REG. DATE <b>1957</b>		24b. REGISTRAR'S SIGNATURE <i>Leverson J. Baranowski</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician, it may be retained by the hospital or attending physician.

VS A15 (4)  
1SM 9/55

BUREAU Y.

JUN 4 1957

KFGEIVFD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06036

6942

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>6 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		d. STREET ADDRESS <b>16 A Merrill Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>16 A Merrill Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>CORA</b>	Middle <b>RYAN</b>	Last <b>LAWRENCE</b>	4. DATE OF DEATH	Month <b>June</b>	Day <b>20,</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 21, 1873</b>	9. AGE (In years lost birthday) <b>84 yrs</b>	IF UNDER 1 YEAR Months <b>84</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Ryan</b>		14. MOTHER'S MAIDEN NAME <b>SARAH <del>Elizab</del> Matheny</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Ruth Lawrence 16 A Merrill Rd. Catonsville</b>		Address <b>Zone 28, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).		<b>Cardiac Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { (b) (c)		<b>Arteriosclerotic Cardi-Vascular Disease</b>					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>	(County) <b>None</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>May 17, 1957</b> , to <b>June 20, 1957</b> , that I last saw the deceased alive on <b>June 18, 1957</b> , and that death occurred at <b>11 E. Chase St.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Michael L. De Vincentis</b>		ADDRESS (Street, city or town, state) <b>11 E. Chase St. Baltimore 2, Md.</b> DATE SIGNED <b>6/20/57</b>					
PHYSICIAN'S NAME (Type) <b>MICHAEL L. DE VINCENTIS, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/25/1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>I. O. O. F. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Craig Missouri</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>		ADDRESS <b>Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 24 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>	

BUREAU V. S.

1-24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
61143 CERTIFICATE OF DEATH

06037

**Reg. Dist. No**

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE		Maryland		b. COUNTY		Baltimore	
Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Catonsville		d. LENGTH OF STAY IN lb		10 months		d. STREET ADDRESS		Pleasant Hill Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Spring Grove Syage Hospital		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First William August Lehnert, Sr.		Middle		Last		4. DATE OF DEATH		Month June 26, Year 19 57	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 8-8-1871		9. AGE (In years lost birthday) 85 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
Widowed <input checked="" type="checkbox"/>		Divorced <input type="checkbox"/>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wagonbuilder		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Ernest Lehnert		14. MOTHER'S MAIDEN NAME Minnie Mullmeyer									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
(Yes, no, or unknown) (If yes, give war or dates of service)				Hospital records, Spring Grove State Hospital							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: Acute cardiac failure											
IMMEDIATE CAUSE (a) DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Aug. 27, 1956, to June 26, 1957, that I last saw the deceased alive on June 26, 1957, and that death occurred at 6:35 A.M. from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)											
DATE SIGNED											
ACTUAL SIGNATURE <i>Louie Frances Woodward</i> M.D. SPRING GROVE STATE HOS. 6-26-57											
PHYSICIAN'S NAME (Type) <i>Louie Frances Woodward, M. D.</i> Spring Grove State Hospital, Catonsville, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/29/57		22c. NAME OF CEMETERY OR CREMATORIAL Spring Grove Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank H. Lovell, Pikesville</i>											
ADDRESS		24a. REG'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
DATE 7 1957											

REGELIV

V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

61144

## CERTIFICATE OF DEATH

06038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Pikesville</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville 8, Md.</b>		d. STREET ADDRESS <b>12 Dreher Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Martha</b>		First	Middle	Last	4. DATE OF DEATH Month <b>June</b>	Day <b>19,</b>	Year <b>19 57</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1889</b>		9. AGE (In years last birthday) <b>88</b> yrs.	10. IF UNDER 1 YEAR; IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Fruitland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elijah Smullen</b>				14. MOTHER'S MAIDEN NAME <b>Lokey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Edward L. Mortimer, 12 Dreher Ave.</b>		Address <b>Pikesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>DEHYDRATION</b>				INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) <b>TOXEMIA</b>					
DUE TO (c)		<b>GENERALIZED ARTERIOSCLEROSIS</b>					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>POST-OPERATIVE MID-THIGH AMPUTATION</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JANUARY 5, 1957</b> to <b>JUNE 19, 1957</b> that I last saw the deceased alive on <b>JUNE 19, 1957</b> and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>6/20/57</b>	
ACTUAL SIGNATURE <b>Samuel P. Scalia</b>				M.D. <b>1331 REISTERSTOWN ROAD</b>			
PHYSICIAN'S NAME (Type) <b>Samuel P. Scalia</b>				<b>PIKESVILLE 8, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Whatcoat Meth. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Snow Hill, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUN 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Lewis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUN 24 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6045

## CERTIFICATE OF DEATH

06039  
88

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Swan - rural</i>		c. LENGTH OF STAY IN 1b <i>x-1</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>702 Regester Ave.</b>		e. STREET ADDRESS <b>702 Regester Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>DAVID HOOD LIVINGSTON</b>		4. DATE OF DEATH <b>June 26 1957</b>	Month Day Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 27, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec.</b>	
10c. BIRTHPLACE (State or foreign country) <b>R. I.</b>		11. CITIZEN OF WHAT COUNTRY? <b>I.</b>	
13. FATHER'S NAME <b>Richard Livingston</b>		14. MOTHER'S MAIDEN NAME <b>Christine Hood</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b> <i>World War I</i>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mrs. Bessie J. Livingston - 702 Regester Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <b>Chronic Decompensation</b> Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH <b>3 Months</b>	
(b) DUE TO <b>6 Month.</b>			
(c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 1, 1948 June 26, 1957</b> , that I last saw the deceased alive on <b>June 24, 1957</b> , and that death occurred at <b>2 p.m.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Charles F. O'Donnell M.D.</i> PHYSICIAN'S NAME (Type) <i>Charles F. O'Donnell, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremated 6-27-57</b>		22b. DATE THEREOF <b>June 27, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Tafttuckett Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Tafttuckett, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kim J. Leekner &amp; Sons</i>		24a. REC'D BY REGISTRAR DATE <b>June 11, 1957 6/27/57</b>	
ADDRESS <i>111 W. Pratt St. Baltimore, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Patsie Gray</i>	

RECEIVED  
BUREAU V. S.

JUN 6 1977

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6046

06040

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3mths28dys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>4220 - 71st Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Just</b>	Middle <b>Thomsen</b>	Last <b>Lund</b>	4. DATE OF DEATH Month <b>June</b>	Day Year <b>17 1957</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 16, 1903</b>	9. AGE (In years last birthday) <b>54 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>economist</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Kristoffer Lund</b>		14. MOTHER'S MAIDEN NAME <b>Berthaena Skot</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>449A</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) DUE TO Generalized and cerebral arteriosclerosis Hypertensive cardiovascular disease				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 22, 1957</b> to <b>June 17, 1957</b> , that I last saw the deceased alive on <b>June 17, 1957</b> , and that death occurred at <b>7:50 p.m.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>6-18-57</b>	
ACTUAL SIGNATURE <b>Stella Wachsler</b>					
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/20/1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Fort Lincoln Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Prince Georges County, Md.</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. J. Hems Co. Washington, D.C.</b>		ADDRESS <b>2901-1451</b>		24a. REC'D. REGISTRAR DATE <b>JUN 20 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

BUREAU V.

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06041  
38

6047

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 6 yrs. 6 months		a. STATE Md. b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 West Joppa Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 1001 West Joppa Road	
3. NAME OF DECEASED (Type or print) Sister Mary Isabel (Lunig)		First	Middle	Last	4. DATE OF DEATH June 20, 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1875	9. AGE (In years last birthday) 82 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (State or foreign country) Philadelphia, Penna.	
13. FATHER'S NAME Nicholas Lunig		14. MOTHER'S MAIDEN NAME Rosalie Hildebrand		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO none		17. INFORMANT Convent Records, 1001 W. Joppa Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  480.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		Coronary Thrombosis 24 hrs. Generalized Arteriosclerosis 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from Sept. 1, 1950, to June 20, 1957, that I last saw the deceased alive on June 19, 1957, and their death occurred at 7:40 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			
ACTUAL Dr. Charles F. O'Donnell		DATE SIGNED JUN 20 1957			
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Convent Cemetery	22d. LOCATION (City, town, or county) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C. Vernon Lemoine		ADDRESS 4611 Park Heights Ave.		24a. REC'D BY REGISTRAR DATE JUN 24 1957	24b. REGISTRAR'S SIGNATURE Mabel Gray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please stamp carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

May 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be filed by the hospital or attending physician, signed by the attending physician, and completely filled in by the funeral director.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06042	
CERTIFICATE OF DEATH										Reg. Dist. No. 44	
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland					b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN 1b 13½ Hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park			d. STREET ADDRESS Route 2, Box 423		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital											
3. NAME OF DECEASED (Type or print)		First MELVIN	Middle W.	Last MADARY	4. DATE OF DEATH June		Month July	Day 7	Year 1956		
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1909		9. AGE (In years lost birthday) 47 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner - retired			10b. KIND OF BUSINESS OR INDUSTRY Restaurant			11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME John Madary						14. MOTHER'S MAIDEN NAME Katherine Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes WW II			16. SOCIAL SECURITY NO 215-05-3864			17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POSTERIOR MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) RIGHT CORONARY THROMBOSIS DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nephrosclerosis										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. VA			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 6, 1957, to June 7, 1957, and that death occurred at 4:45 A.M. from the causes and on the date stated above. Signature: <i>Chien Wei Lan</i> ADDRESS (Street, city or town, state) ACTUAL SIGNATURE M.D. VAH, FT. HOWARD, MARYLAND DATE SIGNED 6/7/57											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6-11-57		22c. NAME OF CEMETERY OR CREMATORIUM Glenhaven Cemetery			22d. LOCATION (City, town, or county) Baltimore, Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE James L. McCully, 237 Patapsco Ave., Balt., Md.						24a. REG'D BY REGISTRAR DATE JUN 10 1957			24b. REGISTRAR'S SIGNATURE <i>James L. McCully</i>		

RECEIVED  
BUREAU V. S.

JN 10

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6949

## CERTIFICATE OF DEATH

06043

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville.</b>		c. LENGTH OF STAY IN 1b <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1919 Rockwell Ave.</b>		d. STREET ADDRESS <b>1919 Rockwell Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JULIA</b>	Middle <b>ANN</b>	Last <b>McCORMICK</b>	4. DATE OF DEATH <b>June 17, 1957</b>	Month Day Year		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1882</b>	9. AGE (In years lost birthday) <b>75 yrs.</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George A. Wright.</b>		14. MOTHER'S MAIDEN NAME <b>Madelina Groh</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT <b>Mrs. Ella Mae Clemens - 1919 Rockwell Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <b>THROMBOSIS, CEREBRAL</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 HOURS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>— x —</b>		(b) DUE TO <b>HYPERTENSIVE CARDIOVASCULAR</b>		10 YEARS			
		(c) DUE TO <b>DISEASE (ELABILE HYPERTENSION)</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		<b>(1) PAGET'S DISEASE; (2) OSTEOARTHRITIS, SEVERE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>5-1</b> , 19 <b>56</b> , to <b>6-17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6-17</b> , 19 <b>57</b> , and that death occurred at <b>4:03 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>401 RANDOM RD., BALTO, MD.</b>		DATE SIGNED <b>6-19-57</b>			
ACTUAL SIGNATURE <i>John F. Schaefer</i>	PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER M.D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/20/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral Cem.</b>	22d. LOCATION (City, town, or county) <b>Balto., Md.</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Schaefer - Balt. 17th</i>	ADDRESS <b>1919 Rockwell Ave. - Balt. 17th</b>	24a. REC'D BY REGISTRAR <b>JUN 19 1957</b>	24b. REGISTRAR'S SIGNATURE <i>DeLancey</i>				

BUREAU V. S.

UN 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

61150

## CERTIFICATE OF DEATH

Reg. Dist. No. 0604437

1 PLACE OF DEATH o COUNTY BALTIMORE MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MT WILSON ST HOSPITAL		d. STREET ADDRESS 2405 E. PRESTON ST.	
3. NAME OF DECEASED (Type or print) First IDA MIDDLE WASHINGTON LAST MC CULLOUGH		4. DATE OF DEATH Month 6 Day 2 Year 1957	
5. SEX FEMALE COLOR OR RACE WHITE		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. DATE OF BIRTH 2.22.1875		8. AGE (In years lost birthday) 82 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY BURKHEAD		14. MOTHER'S MAIDEN NAME CATHERINE SWORMJTEPT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) MITRAL DISEASE, GENERALIZED ARTERIOSCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 4.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. : 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7.5.1951 to 6.2.1957, that I last saw the deceased alive on 6.2.1957, and that death occurred at 3:45 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William Newcomer, M.D.			
PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent Mt. Wilson, Maryland			
22a. BURIAL, CREMATION. BURIAL		22b. DATE THEREOF 6-5-57	
22c. NAME OF CEMETERY OR CREMATORIAL Cem.		22d. LOCATION (City, town or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc. -2431 E. Oliver St.		24a. RECORDS REGISTRAR JUN 4 1957	
		25. REGISTRAR'S SIGNATURE, John C. Miller Inc.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. A.  
RECEIVED

JUN 4 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, file the funeral director.  
 Page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6051

## CERTIFICATE OF DEATH

06045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NOTCH CLIFF NEAR TOWSON</b>		c. LENGTH OF STAY IN lb <b>X</b> NOTCH CLIFF NEAR TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENARM ROAD</b>		d. STREET ADDRESS <b>GLENARM ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SISTER MARY HILDA GILVRAY</b>		First <b>M</b>	Middle <b>C</b>
4. DATE OF DEATH Month <b>JUNE</b>		Last <b>18</b>	Year <b>1957</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 26, 1872</b>
9. AGE (In years last birthday) <b>84 yrs</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>0</b>	Days <b>0</b>
11. BIRTHPLACE (State or foreign country) <b>BOSTON MASS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM MC GILVRAY</b>		14. MOTHER'S MAIDEN NAME <b>ISABEL HOGAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>17. INFORMANT SISTER M. PETER FOURIER NOTCH CLIFF MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDITIS</b>		19. INTERVAL BETWEEN ONSET AND DEATH	
422.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO			
{ DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>645 A.M.</b>
20f. (City or town) <b>TOWSON</b>		(County) <b>MARYLAND</b>	
(State) <b>MARYLAND</b>			
21. I certify that I attended the deceased from <b>APRIL 1957</b> to <b>JUNE 1957</b> , that I last saw the deceased alive on <b>APRIL 9th 1957</b> , and that death occurred at <b>645 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>CHARLES F O'Donnell</b>		ADDRESS (Street, city or town, state) <b>M.D. 7501 YORK RD. TOWSON MD.</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES F O'Donnell</b>		DATE SIGNED <b>6/18/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-21-57.</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>VILLA MARIA CEM</b>
22d. LOCATION (City, town, or county) <b>NOTCH CLIFF NR TOWSON, MD.</b>		(State) <b>MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles F O'Donnell</b>		24a. ADDRESS <b>401 S. CONKLING ST.</b>	24b. REC'D BY REGISTRAR <b>6/21/57</b>
		DATE <b>6/21/57</b>	24c. REGISTRAR'S SIGNATURE <b>Frances E. Kelly</b>

BUREAU Y. A.

JUN 9 1 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06046

6-52

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Pr. Ged.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Hyrlmth10dys									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.									
3. NAME OF DECEASED (Type or print) Louise		d. STREET ADDRESS Rroute #1 Sargeant Rd.									
4. DATE OF DEATH June 25		Month Year Day Year	5. SEX female	First white	Middle WIDOWED <input checked="" type="checkbox"/>	Last DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH unknown	9. AGE (In years last birthday) 82? yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME unk. own									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)				Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH					
Arteriosclerosis, generalized											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from May 11, 1953, to June 25, 1957, that I last saw the deceased alive on June 25, 1957, and that death occurred at 3:15 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>Stella Wachsler</i>						ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL		DATE SIGNED 6-25-57			
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/57		22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery		22d. LOCATION (City, town, or county) Washington D. C.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>James A. Koch's Sons</i>		ADDRESS 4383 Baltimore, Md.		24a. REC'D BY REGISTRAR DATE JUL 1 57		24b. REGISTRAR'S SIGNATURE <i>John E. Koch</i>					

TO SIGHTED OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

KIEGEIY EL

JUL 1 1952

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

6053

## CERTIFICATE OF DEATH

06047

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Baltimore</i>		b. COUNTY <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Catonsville</i>		<i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>5898 Old Fred. Rd.</i>	<i>5898 Old Frederick Rd.</i>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<i>Ella</i>	<i>Theresa</i>	<i>mc larva</i>	<i>6</i>
4. DATE OF DEATH	Month	Day	Year
<i>4-1-04</i>	<i>6</i>	<i>11</i>	<i>1957</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<i>F</i>	<i>C</i>		<i>4-1-04</i>
9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
<i>53 yrs</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>School Teacher</i>		<i>-</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Calvert Co. Md.</i>		<i>Rd.</i>	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<i>George White</i>	<i>Maggie Lucks</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
(If yes, give war or dates of service)			<i>Robert S. Mc larva - 5898 Old Fred. Rd.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>443X</i> DUE TO <i>Atrial Insufficiency</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiac Disease</i>			
DUE TO ? (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
443X			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/17/57</i> , 19, to <i>6/11/57</i> , 19, that I last saw the deceased alive on <i>7/II/57</i> , 19, and that death occurred at <i>130 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B.F. Maloney</i>		ADDRESS (Street, city or town, state) <i>57 Winters Lane</i> DATE SIGNED <i>5/II/57</i>	
PHYSICIAN'S NAME (Type) <i>C.F. Maloney, M.D.</i>		Catoonsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-14-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore National</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel W. Sullivan Jr.</i>		ADDRESS <i>Baltimore</i>	
24a. REC'D BY REGISTRAR <i>John J. 13 '57</i>		24b. REGISTRAR'S SIGNATURE <i>John J. 13 '57</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AITS (4)  
15M 9/55

RECEIVED  
BUREAU V. S.

JUN 13 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06048

6754

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN 1b

2 months

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

SPRING GROVE STATE HOSP.

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE OF DEATH

June 22 1957

S SEX

6 COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9 AGE (In years  
lost birthday)10 IF UNDER 1 YEAR  
Months Days11 IF UNDER 24 HRS  
Hours Min.

M.

W.

WIDOWED DIVORCED 

7-9-1891

65

yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Railroad Firemen

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

7-9-1891, New York U.S.A.

13. FATHER'S NAME

Harrison W. McLaughlin

14. MOTHER'S MAIDEN NAME

Harrison Catherine Finn

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give war or dates of service)

None

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

072-09-1008

Alice McLaughlin 9-D Southway Greenbelt MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Congestive Heart failure

INTERVAL BETWEEN  
ONSET AND DEATH

11-23-1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

(b)

DUE TO

Arteriosclerotic cardiovascular disease

(c)

Generalized arteriosclerosis

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 

Peptic ulcer

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)

20c. TIME OF INJURY Month, Day, Year  
Hour o.m.  
p.m.20d. INJURY OCCURRED  
While  
Not while  
of work  of work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from April 23, 1957, to June 22, 1957, that I last saw the deceased alive on June 22, 1957, and that death occurred at 10:35 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Stella Wachsler

M.D.

SPRING GROVE STATE HOSPITAL

6-24-57

PHYSICIAN'S  
NAME (Type)

Stella Wachsler, M.D.

Catonsville 28, Maryland

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

Burial

6/26/57

22c. NAME OF CEMETERY OR CREMATORIUM

Mt. Olivet Cemetery

22d. LOCATION (City, town, or county)

Washington, D.C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS (Street, city or town, state)

V.L. W. Chambers Co

5801 4th Riverdale

24a. REC'D. BY REGISTRAR

JUN 27 1957

DATE

24b. REGISTRAR'S SIGNATURE

W. Chambers

DATE

BUREAU V. A.  
RECEIVED  
1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6055 CERTIFICATE OF DEATH

06050

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			b. COUNTY <b>Balto.</b>			
c. LENGTH OF STAY IN 1b <b>30 yrs</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>123 Longview Dr.</b>			d. STREET ADDRESS <b>123 Longview Dr.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Teresa</b>		First <b>M.</b>	Middle <b>Meier</b>	Last <b>June</b>	Month <b>3</b> , Year <b>1957</b>	
4. DATE OF DEATH	Month	Day	Year			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25, 1904</b>	9. AGE (In years last birthday) <b>53</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>William Tribbe</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Robert J. Meier Sr., 123 Longview Dr.</b>		
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>155x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) Adeno CARCINOMA OF Liver AND Gallbladder						INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)						
21. I certify that I attended the deceased from <b>February 11, 1957</b> to <b>June 3, 1957</b> , that I last saw the deceased alive on <b>June 3, 1957</b> , and that death occurred at <b>11:50 PM</b> , from the causes and on the date stated above.						
ADDRESS (Street, city or town, state)						
DATE SIGNED						
ACTUAL SIGNATURE <b>Melvin N. Borden</b>		M.D. <b>5000 BALTIMORE NATIONAL</b>				
PHYSICIAN'S NAME (Type) <b>Melvin N. BORDEN</b>		Pike BALTO MD 4/6/57				
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 7/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Meadowridge Cem.</b>		
22d. LOCATION (City, town, or county) <b>Dorsey Md.</b>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson</b>		ADDRESS <b>Witzke Funeral Directors, 4101 Edmondson</b>		24a. REGISTRY BY REGISTRY BAR <b>SUN</b>		
				24b. REGISTRAR'S SIGNATURE <b>Witzke</b>		

BUREAU V. S.

JUN 16 1965

KFG677V16U

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06051

6156

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>	c. LENGTH OF STAY IN lb <b>7 yr 6 mo 14 da</b>	b. COUNTY <b>BALTIMORE</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BALTIMORE COUNTY HOME</b>	d. STREET ADDRESS <b>M</b>		
3. NAME OF DECEASED (Type or print) <b>Harry C. MENKERT</b>	First <b>Harry</b>	Middle <b>C.</b>	Last <b>MENKERT</b>
4. DATE OF DEATH <b>JUNE 28 1957</b>	Month <b>JUNE</b>	Day <b>28</b>	Year <b>1957</b>
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 17, 1864</b>
9. AGE (In years lost birthday) <b>93 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COFFEE MERCHANT</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>COFFEE</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>FREDERICK MENKERT</b>	14. MOTHER'S MAIDEN NAME <b>MARGARET ?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>MISS JEAN SISK</b>	Address <b>583 Woodbine Ave., TOWSON</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiac-vascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woodlawn Cemetery</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>alive</b> , 19 <sup>49</sup> , to <b>Towson</b> , 19 <sup>57</sup> , that I last saw the deceased alive on <b>June 25</b> , 19 <sup>57</sup> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elizabeth B. Sherrill</b>	PHYSICIAN'S NAME (Type) <b>Elizabeth B. Sherrill</b>	ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>	DATE SIGNED <b>6/28/57</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Jun. 29, 1957</b>	22b. DATE THEREOF <b>Woodlawn Cemetery</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>
24a. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Sons, Towson, Md.</b>	ADDRESS <b>John Burns Sons, Towson, Md.</b>	24b. REC'D BY REGISTRAR DATE <b>6/28/57</b>	24c. REGISTRAR'S SIGNATURE <b>J.W. J. Belmont</b>

CLUBAU V. 3  
1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06052

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>100 Stevens Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 Oak Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>HARRIET</b>	Middle <b>W.</b>	Last <b>MENOCHER</b>	4. DATE OF DEATH <b>June 8, 1957</b>	Month <b>June</b>	Day <b>8</b>	Year <b>1957</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30, 1871</b>		9. AGE (in years last birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>George W. Walker</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Cramer</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Edward Simmons, Jr. - 15 Tanglewood Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive occlusion</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 mon.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <i>atherosclerotic cardiovascular disease</i>						5 yrs +	
(c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>gall bladder disease</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Elkridge, Md.</b>	(County) (State) <b>Elkridge, Md.</b>
21. I certify that I attended the deceased from <b>1952</b> , 19, to <b>June 8</b> , 1957, that I last saw the deceased alive on <b>May</b> , 1952, and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>1118 St. Paul St.</b>		DATE SIGNED <b>J. H. A. Nesbitt, Jr.</b>	
ACTUAL SIGNATURE <b>J. H. A. Nesbitt, Jr.</b>		NAME (Type) <b>J. H. A. Nesbitt, Jr.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Meadowridge Mem. Pk.</b>		22d. LOCATION (City, town, or county) <b>Elkridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Listerer &amp; Sons - Balt. Md.</b>		ADDRESS <b>1118 St. Paul St.</b>		24a. REC'D BY REGISTRAR <b>1/2/57</b>		24b. REGISTRAR'S SIGNATURE <b>J. H. Nesbitt</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUN 13 1957

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6058

## CERTIFICATE OF DEATH

06053

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>		b. COUNTY <b>PRINCE GEORGE'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <b>16 yrs 1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SEASIDE PLEASANT</b>		d. STREET ADDRESS —	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>SUSANNA</b>	Middle	Last <b>MESSINGER</b>	4. DATE OF DEATH Month <b>6</b>	Month <b>30</b>	Day <b>19</b>	Year <b>57</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 27-1885</b>	9. AGE (In years from birthday) <b>72</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>		11. BIRTHPLACE (State, or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Messinger</b>		14. MOTHER'S MAIDEN NAME <b>Catherine White</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 17. INFORMANT <b>JOHN MESSINGER - 4008-378 ST. MT. RAINIER, MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Coronary and generalized arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Thrombosis, left renal artery</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>July 1, 1955</b> , to <b>June 30, 1957</b> , that I last saw the deceased alive on <b>June 30, 1957</b> , and that death occurred at <b>9:30 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL 7-1-57</b>							
DATE SIGNED							
ACTUAL SIGNATURE <i>Isadore Tuerk</i>		PHYSICIAN'S NAME (Type) <b>Isadore Tuerk, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 3, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Road Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Maryland.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JUL 3 '57</b>		24b. REGISTRAR'S SIGNATURE <b>Al Seach</b>	

1940 A.D.

L 3 1957

LIBRARY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06054

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN lb 5 Days XX		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UPPER MARLBORO		d. STREET ADDRESS Main Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ALBERT	Middle	Last MICHEL	4. DATE OF DEATH JUN 12	Month 24	Day 19	Year 57
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-30-1887	9. AGE (In years at birthday) 67	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
13. USUAL OCCUPATION (kind of work done)		10. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADAM MICHEL		14. MOTHER'S MAIDEN NAME Magdeline Feile					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL APoplexy</u>						INTERVAL BETWEEN ONSET AND DEATH 5 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) <u>ARTERIOSCLEROSIS</u>				uncertain	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m p. m		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>June 12</u> , 1957, to <u>June 24</u> , 1957, that I last saw the deceased alive on <u>June 24</u> , 1957, and that death occurred at <u>2:55 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>William Newcomer</u> M.D. Mt. Wilson, Maryland		ADDRESS (Street, city or town, state) DATE SIGNED <u>6/24/57</u>					
PHYSICIAN'S NAME (Type) William Newcomer, M. D., Superintendent							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/57		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery		22d. LOCATION (City, town, or county) Upper Marlboro, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home-Marlboro, Md.		ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR JUN 28 1957		24b. REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with Page 3 so as to be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.  
RECEIVED  
JUN 6 1965

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6/60

06055

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Catonsville		c. LENGTH OF STAY IN 1b  Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5937 Johnnycake Rd.		d. STREET ADDRESS 5937 Johnnycake Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Elizabeth	Middle Middleton	Last Last
4. DATE OF DEATH	Month June	Day 10	Year 57 19
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1892
9. AGE (In years lost birthday) 64 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY U.S.A.
14. FATHER'S NAME James Bedwell	14. MOTHER'S MAIDEN NAME Sarah Lloyd	Address Earl Williams Middletown, Del.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 44.1 X DUE TO CARDIAC FAILURE INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE (c)		12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 3101 W Baltimore St.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 10, 1950, to June 10, 1957, that I last saw the deceased alive on June 9, 1957, and that death occurred at 3:00 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE KENNARD YAFFE M.D. DATE SIGNED PHYSICIAN'S NAME (Type) KENNARD YAFFE M.D. 6/12/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 13, 1957	22c. NAME OF CEMETERY OR CREMATORIAL Bethel Cemetery	22d. LOCATION (City, town, or county) Chesapeake City Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home	ADDRESS Catonsville, Md.	24a. REC'D BY REGISTRAR DATE JUN 14 '57	24b. REGISTRAR'S SIGNATURE Alfred

BUREAU V.

JUN 14 1957

RECEIVED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar; 2 or 3 with the registrar, cremation, or removal.

Items 19&20 Film #1  
6-61 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> <b>SPARROWS POINT</b>		c. LENGTH OF STAY IN lb <b>5YS, 9MNT</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethlehem Steel Co. Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE SPARROWS POINT 19</b>	
f. STREET ADDRESS <b>1244 Haddaway Rd.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROBERT MILTON MONGOLD, JR.</b>		First <b>ROBERT</b>	Middle <b>MILTON</b>
Last <b>MONGOLD, JR.</b>		Last <b>MONGOLD, JR.</b>	4. DATE OF DEATH <b>6-11-57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 26, 1920</b>
9. AGE (in years from birthday) <b>36 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP REPAIR.</b>	11. BIRTHPLACE (State or foreign country) <b>W. VA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>R. M. MONGOLD</b>	
14. MOTHER'S MAIDEN NAME <b>ZETTIE BOWMAN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>YES</b> <b>WW II</b>	
16. SOCIAL SECURITY NO. <b>214-05-5524</b>		17. INFORMANT <b>MYRILLE VAN P. MONGOLD - SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <b>Compound fracture skull. Fracture, left tibia and fibula, right femur.</b>			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Compound fracture skull. Fracture, left tibia and fibula, right femur.</b> DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Fell 90 feet from crane at shipyard</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell 90 feet from crane at shipyard</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>8:40 AM 6-11-57</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Beth.Sy.Pt.Syd. Inc. Sparrows Point 19, Balto. Co.</b>
(City or town) (County) (State) <b>W. VA</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B. Davis</b>		DATE SIGNED <b>6-11-57</b>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>WATER</b>	22b. DATE THEREOF <b>6-15-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>KEYSER CEM.</b>	22d. LOCATION (City, town, or county) <b>KEYSER, W. VA.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Bradley, Kendall, Md.</b>		ADDRESS	24a. REC'D BY REGISTRAR <b>JUN 14 1957</b>
			24b. REGISTRAR'S SIGNATURE <b>J. Dawson J. Farley</b>

BUREAU V. E.

JUN 14 1957

RECEIVED

6/14/57

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

(06057  
44

## 6062 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your reference. File Pages 1 and 2 with the registrar, or for burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sparrows Point Hospital-Beth. Steel</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sanford N.M.N.</b>	First Middle MORTON	4. DATE OF DEATH Month 6 Day 24 Year 1957	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-98</b>
9. AGE (In years from birthday) <b>58 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Narrow Gauge Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Nicie Morton</b>		14. MOTHER'S MAIDEN NAME <b>Unknwn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-07-3451</b>	
17. INFORMANT <b>Harp Berndt</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decapitation-Evisceration-Multiple compound fractures-Complete crushing of body.</b>			
DUE TO (b) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.</b>			
DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Fell under narrow gauge drag.</b>	
20c. TIME OF INJURY Hour <b>11:25</b> p.m.		Month, Day, Year <b>6-24-57</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) <b>B. S. Plant</b>		20f. (City or town) <b>Sp. Pt.</b>	(County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>M.B. Davis, M.D.</b>		DATE SIGNED <b>6-25-57</b>	
EXAMINER'S NAME (Type) <b>M. B. Davis, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. FUNERAL CREMATION, REMOVAL (Specify) <b>Funeral</b>		22b. DATE THEREOF <b>June 28</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt Calvary</b>		22d. LOCATION (City, town, or county) <b>A.A. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Eliroy O Wilson</b>		24a. REG'D BY REGISTRAR DATE <b>6/25/57</b>	
		24b. STRAR'S SIGNATURE <b>Dawson L. Foster</b>	

BUERAU V. 8

11 3 1957

REGELIVEL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06058

6963

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY		Rosewood State Training School Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN 1b 8 1/2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		d. STREET ADDRESS 1525 West Baltimore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First Dianne	Middle Eileen	Lost Mowbrey	4. DATE OF DEATH 6	Month 14	Day 19	Year 57
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/14/47	C. AGE (In years last birthday) 9 10 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0	Min. 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Baltimore, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13 FATHER'S NAME Robert H. Mowbrey		14 MOTHER'S MAIDEN NAME Gertrude May Beach Ford		Address				
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16 SOCIAL SECURITY NO		17. INFORMANT Rosewood Records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Hydranencephaly (c) Early infant brain damage						INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Idiocy, cerebral palsy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1525 West Baltimore Street	20f. (City or town) Baltimore	(County) Baltimore	(State) MD		
21. I certify that I attended the deceased from 11/19/48, 19, to 6/14/57, 19, that I last saw the deceased alive on 6/14/57, 19, and that death occurred at 7:05 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE Rich. Hindenber		M.D.						
PHYSICIAN'S NAME (Type) Rich. Hindenber		Rosewood State Training School						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1948		22c. NAME OF CEMETERY OR Crematory 1525 West Baltimore Street		22d. LOCATION (City, town or county) Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE Frank J. Neveil, Baltimore		ADDRESS		24a. REC'D BY REGISTRAR DATE 6/18/57		24b. REGISTRAR'S SIGNATURE		

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The funeral director, to funeral director, may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6964

## CERTIFICATE OF DEATH

06059

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		11. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN lb		a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4303 Soth Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		d. STREET ADDRESS <b>4303 Soth Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Mrs. Eupha A. Mullan</b>		4. DATE OF DEATH <b>June 5th 1957</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 7, 1882</b>	9. AGE (In years lost birthday) <b>75 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b> IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>James Farmer</b>		14. MOTHER'S MAIDEN NAME <b>Eupha Maxwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Miss Eupha Mullan, 4303 Soth Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Coronary Thrombosis</b> (c) <b>Arteriosclerotic Heart Disease</b>				Address <b>2 days</b> <b>10 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>602-32 13th Ave. S.</b>	
20f. (City or town) <b>Baltimore, Maryland</b>				(County) <b>City of Baltimore</b> (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>June 2, 1957</b> to <b>June 5, 1957</b> , that I last saw the deceased alive on <b>June 5, 1957</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Baltimore, Maryland</b>	
ACTUAL SIGNATURE <b>Adams G. Lewis</b>		M.D. <b>Adams G. Lewis</b>		DATE SIGNED <b>June 5, 1957</b>	
PHYSICIAN'S NAME (Type) <b>Adams G. Lewis</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/8/1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Redeemer Cem.</b>	
22d. LOCATION (City, town or county) <b>Baltimore, Maryland</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Hargrave Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>6/10/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Leonard J. Ruck</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use or the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

IN 1952

REGEV E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06060

6-65

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)	
<i>Baltimore</i>		a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson #4</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson #4</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1106 Stevenson Lane</i>		d. STREET ADDRESS <i>1106 Stevenson Lane</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>HELEN</i>	Middle <i>AMELIA</i>	Last <i>MYERLY</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 25 1893</i>
9. AGE (In years at birthday) <i>63 yrs</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	11. MONTH <i>June</i>	12. DAY <i>16</i>
13. FATHER'S NAME <i>William F Rappe</i>	14. MOTHER'S MAIDEN NAME <i>Josephine Smith</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT <i>George H Myerly Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMA OF SIGMOID COLON</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Towson</i> (County) <i>Md.</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Sept. 16, 1956</i> , to <i>June 16, 1957</i> , that I last saw the deceased alive on <i>June 16, 1957</i> , and that death occurred at <i>12:15 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>TIMONIUM, MD</i> DATE SIGNED <i>6/16/57</i>			
ACTUAL SIGNATURE <i>William A. Pillsbury</i>	PHYSICIAN'S NAME (Type) <i>WILLIAM A. PILLSBURY</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial June 19/57</i>	22b. DATE THEREOF <i>June 19/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Prospect Hill</i>	22d. LOCATION (City, town, or county) <i>Towson</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Jenkins</i>		ADDRESS <i>1106 Stevenson Lane Towson Md.</i>	24a. REC'D BY REGISTRAR <i>JUN 20 1957</i> DATE <i>June 20 1957</i>
			24b. REGISTRAR'S SIGNATURE <i>Natalie Gray</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

RECEIVED  
MAY 21 1957

DEAU V. G.

1 DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. To burial, cremation, or removal.

V.S. A15ME(S)  
5M 9/35

6066 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06061

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sprinklers Pr - 19</u>		c. LENGTH OF STAY IN 1b c. STREET ADDRESS <u>EDGEMERE</u> <u>2529 Schoolhouse Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jones Creek -</u>		d. DATE OF DEATH JUNE 22 1957	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) <u>DAVID LEE MYERS</u>	
4. SEX <u>M</u>		First <u>D</u>	Middle <u>A</u>
5. COLOR OR RACE <u>W</u>		6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 7. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>July 9/44</u>	8. AGE (In years last birthday) <u>12</u> yr.
9. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		10. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leslie I. Myers</u>		14. MOTHER'S MAIDEN NAME <u>Verna Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>                        </u>	
17. INFORMANT <u>Verna Brooks 2529 School House Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> DUE TO <u>12/18</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>                        </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PR.MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fall from Snow Tube in Jones Creek</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:00 p.m. 6-22 1957</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Jones Creek</u> 20f. CITY OR TOWN <u>Baltimore Md.</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>M.B. Davis</u>		DATE SIGNED <u>6/22/57</u>	
EXAMINER'S NAME (Type) <u>M.B. Davis M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremated</u>		22b. DATE THEREOF <u>6-23-57</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Jenner's Cemetery</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home, PENDALE, MD.</u>		22d. LOCATION (City, town, or county) <u>Blackburg, Va.</u> (State)	24a. REC'D BY REGISTRAR <u>                        </u>
ADDRESS <u>                        </u>		24b. REGISTRAR'S SIGNATURE <u>Dawson L. Taylor</u>	DATE <u>6/24/57</u>

REGEV E  
RUREAU V.

JUN 25 1957

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PHA3. Pages 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. File page 4 with the registrar for burial/cremation.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 61167 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. <i>06062</i>	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i> BALTIMORE			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>			d. STREET ADDRESS <i>1515 Park Ave. #17</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bethlehem Steel Co. Hospital</i>											
3. NAME OF DECEASED (Type or print)		First Wheeler	Middle Estes	Last Nicholson	4. DATE OF DEATH 6-24-57	Month	Day	Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1900	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>										
10. USUAL OCCUPATION (Give kind of work done During most of working life, even if retired) <i>Painter</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Bethlehem Steel</i>			11. BIRTHPLACE (State or foreign country) <i>Syria, Va</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Tiny Nicholson</i>					14. MOTHER'S MAIDEN NAME <i>Mary (unknown)</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. <i>223-20-4059</i>			17. INFORMANT <i>Mrs. Ruth L. Nicholson, 1515 Park Avenue</i>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)  DUE TO  (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. (None)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
<i>M.B. Davis, M.D.</i>										DATE SIGNED <i>6-24-57</i>	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <i>M.B. Davis, M.D.</i>										DATE SIGNED <i>6-24-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-27-57</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Frostburg Memorial Park</i>			22d. LOCATION (City, town, or county) (State) <i>Frostburg, Maryland</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Cook, Inc., 1217 St. Paul Street</i>										24a. REC'D BY REGISTRAR <i>JDN 26 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Lanson L. Davis</i>
VS. AISM(E)5 SM 9/55											

RECEIVE  
BUREAU V. S.

J - A 1957

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06063

Reg. Dist. No.

5941

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar or removal.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN lb <b>.3 YRS</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>IN BACK RIVER - ADJACENT TO 4233 LYNHURST RD.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>	
3. NAME OF DECEASED (Type or print) <b>CHRISTINA LYNN NODONLY</b>		d. STREET ADDRESS <b>14233 LYNHURST RD.</b>	
4. DATE OF DEATH <b>6-11-57</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F/F</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>31 JULY 1954</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>ALEXANDER</b>	14. MOTHER'S MAIDEN NAME <b>EVELYN J. NODONLY</b>	Address <b>SAME</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <b>—</b>	16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>H. NODONLY</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DROWNING</b> 1.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>—</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>—</b>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Chest wound to water</b>		
20c. TIME OF INJURY Month, Day, Year <b>8:00 p.m. 6-11 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>BACIO RIVER RR. SP. PT. 14 BALTO. MD.</b>	20f. (City or town) <b>County</b> <b>(State)</b> <b>14 BALTO. MD.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <b>M.B. Davis</b>			
ACTUAL SIGNATURE <b>M.B. Davis</b>	DATE SIGNED <b>6-11-57</b>		
EXAMINER'S NAME (Type) <b>M. B. DAVIS MD</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-15-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>MORELAND MEM.</b>	22d. LOCATION (City, town, or county) <b>BALTO. CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Duke Bradley, Newell 22, MD</b>	ADDRESS <b>—</b>	24a. REC'D BY REGISTRAR <b>DAW 14 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Jim. E. Davis</b>

BUREAU Y.

JUN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6068 CERTIFICATE OF DEATH

06064-  
33-

Reg. Dist. No.

M

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shown detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Hall</i>		c. LENGTH OF STAY IN 1b <i>74 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Vernon Rd.-</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - White Hall</i>	
f. STREET ADDRESS <i>Vernon Rd.-</i>		g. STREET ADDRESS <i>Vernon Rd.-</i>	
h. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William E. Norris.</i>		First <i>W</i>	Middle <i>E.</i>
4. DATE OF DEATH <i>June 2</i>		Month <i>June</i>	Day <i>2</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Dec. 4, 1872</i>		9. AGE (In years, months and days) <i>84 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Farm.</i>	
10c. BIRTHPLACE (State or foreign country) <i>White Hall, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Wm H. Norris.</i>		14. MOTHER'S MAIDEN NAME <i>Emma J. Richardson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Cecil B. Norris, White Hall, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>	
DUE TO <i>332+</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Unsevered Arteri-sclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>May 27, 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Parkton, Md.</i>	
20f. (City or town) <i>Parkton, Md.</i>		(County) <i>Parkton, Md.</i>	
(State) <i>Parkton, Md.</i>			
21. I certify that I attended the deceased from <i>May 27, 1957</i> to <i>June 2, 1957</i> , that I last saw the deceased alive on <i>May 27, 1957</i> , and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. M. France</i>		ADDRESS (Street, city or town, state) <i>Parkton, Md.</i>	
PHYSICIAN'S NAME (Type) <i>A. M. FRANCE</i>		DATE SIGNED <i>6/7/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/5/57</i>	
22c. NAME OF CEMETERY OR Crematory <i>Vernon Cemetery</i>		22d. LOCATION (City, town or county) <i>White Hall, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Franklin L. France</i>		24a. REC'D BY REGISTRAR <i>—</i>	
ADDRESS <i>Franklin L. France</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	
DATE <i>6/5/57</i>		DATE <i>6/5/57</i>	

BUREAU V. S.

JUN 6 1957

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in, the funeral director, the third party of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

06065

**CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND LENGTH OF STAY (in this place)	STATE <u>Md</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY <u>BALTIMORE</u> (If rural give location)
TOWN <u>GATONSVILLE</u>	<u>8 months</u>	STREET ADDRESS <u>217 S. HILTON ST.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hood Nursing Home</u>			
<b>3. NAME OF DECEASED (First) (Middle) (Last)</b>		<b>4. DATE OF DEATH</b> <u>6 - 21 - 57</u>	
SEX <u>Female</u>	COLOR OR RACE <u>White</u>	SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	DATE OF BIRTH <u>JUNE 26, 1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	AGE last birthday <u>62 yrs</u>
10b. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALICE DANFORTH</u>		14. MOTHER'S MADDEN NAME <u>IDA M. IDLESBERGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT & ADDRESS <u>Doris Brynn 217 S. Hilton St.</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
IMMEDIATE CAUSE (A) <u>arteriosclerotic C.V.D</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>MEADOWBRIDGE</u>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) <u>M.D.</u> (State) <u>MARYLAND</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M. 21 1957</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAY 21, 1954</u> , to <u>JUNE 21, 1957</u> , that I last saw the deceased alive on <u>JUNE 17, 1957</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>George L. Schubert</u> ADDRESS (Street, city, town, state) <u>3323 Frederick Ave</u> DATE SIGNED <u>6/8/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6-21-57</u>	NAME OF CEMETERY OR CREMATORIUM <u>MEADOWBRIDGE</u>
24. REC'D BY REGISTRAR DATE <u>JUN 20 1957</u>		REGISTRAR'S SIGNATURE <u>Reuben</u>	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>George L. Schubert 3101 Frederick</u>			

BUREAU Y.

UN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06066

6970

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>5mths ldy</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b>		
3. NAME OF DECEASED (Type or print) <b>John</b>			First <b>FRANK</b>	Middle <b>O'Donnell</b>	Last <b>June 18 1957</b>
4. DATE OF DEATH <b>June 18 1957</b>			Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>
5. SEX <b>male</b>			6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>1870, Oct. 15</b>
					9. AGE (In years last birthday) <b>83 83 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown Soldier 1st C. U.S. Army</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>England</b>
13. FATHER'S NAME <b>unknown</b>			14. MOTHER'S MAIDEN NAME <b>unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16. SOCIAL SECURITY NO. <b>10-181-226</b>	17. INFORMANT <b>Mrs. Chas. Parks - 3552 Horton Avenue - 25</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] daughter			INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <b>Arteriosclerosis, generalized and severe</b>					
DUE TO					
(b) <b>Arteriosclerosis, generalized and severe</b>					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>SPRING GROVE STATE HOSPITAL</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 11, 1957</b> to <b>June 18, 1957</b> , that I last saw the deceased alive on <b>June 18, 1957</b> , and that death occurred at <b>3:25 P.M.</b> from the causes and on the date stated above			ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> 6-19-57		
ACTUAL SIGNATURE <b>Stella Vachslcr</b>			DATE SIGNED		
PHYSICIAN'S NAME (Type) <b>Stella Vachslcr, M. D.</b>			Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial June 24, 1957</b>		22b. DATE THEREOF <b>June 24, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Cross Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Ridgeley, Anne Arundel Co.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Jones</b>		ADDRESS <b>4001 Ridgeway</b>	(25)	24a. REC'D BY REGISTRAR <b>6/24/57</b>	24b. REGISTRAR'S SIGNATURE <b>H. H. Hildner</b>

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 3 should be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

REGEI V. E.  
BUREAU V. S.

U.S.A. 1957

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06067

6/71

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN 1b

10mths8dys

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION  
SPRING GROVE STATE HOSPITAL

d. STREET ADDRESS

2003 W. Pratt St.

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

S. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (in years  
lost birthday)  
yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS

female

white

WIDOWED DIVORCED 

March 21, 1895

Months

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

unknown

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

New Hampshire

U. S. A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Records: SPRING GROVE STATE HOS. ITAL

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

coronary occlusion

INTERVAL BETWEEN  
ONSET AND DEATH

unknown

DUE TO

420.1

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause lost.

DUE TO

(b)

arteriovenous cardio vascular

(c)

disease

MEDICAL CERTIFICATION

Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

420.1

lethal brain disease

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING 

CAUSE OF DEATH

(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a. m.

19

p. m.

20d. INJURY OCCURRED

White Not white  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 17, 1957, to June 21, 1957, that I last saw the deceased  
alive on June 21, 1957, and that death occurred at 5:40 PM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

M.D. SPRING GROVE STATE HOS. ITAL

6-21-57

PHYSICIAN'S  
NAME (Type)

John M. VASCONCELLOS

Catonsville 28, Maryland

220. BURIAL, CREMATION,  
REMOVAL (Specify)

6-21-57

1

22b. DATE THEREOF

6-21-57

22c. NAME OF CEMETERY OR CREMATORIUM

Louden Park

22d. LOCATION (City, town, or county)

Baltimore, Maryland

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

George L. Schwab

2101 Frederick Ave

ADDRESS

JUN 24 1957

24a. REC'D BY REGISTRAR

D. Schulz

24b. REGISTRAR'S SIGNATURE

RECEIVED  
BUREAU V. S.

JUN 1 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06068

6178

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Maryland		b. COUNTY Maryland							
c. LENGTH OF STAY IN 1b		62 w.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		9301 Old Harford Rd.		d. STREET ADDRESS							
e. FIRST MIDDLE LAST		Frank Elbert Old		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
f. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) 99 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
Male		White				Aug 24 1877		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
None				Penn.							
13. FATHER'S NAME		William Chastine Clef.		14. MOTHER'S MADDEN NAME		Mary Belle Crawford					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		None		Address			
No		-		None							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Sensitivity & Cachexia		INTERVAL BETWEEN ONSET AND DEATH 1 yr.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Age - Possible Ca of Larynx							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Age - Possible Ca of Larynx							
Part II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m pm		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
20c. TIME OF INJURY Month, Day, Year Hour o. m pm		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ACTUAL SIGNATURE		FRANK T. KASIK JR. M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED 6/18/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/57		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge		22d. LOCATION (City, town, or county) Pikesville, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE K. W. Meeks		ADDRESS 1600 Meeks Ave. Bon Secours N. Calvert St.		24a. REC'D BY REGISTRAR JUN 18 1957		24b. REGISTRAR'S SIGNATURE John J. Meeks					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file in the funeral director's office. Do not detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUN 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06069

6973

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hoods Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Elizabeth</i>	Middle <i>T.</i>	Last <i>Olmer</i>		
4. DATE OF DEATH	Month June	Day 17	Year 1957		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 12, 1875</i>		
9. AGE (In years from birthday) 82 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Operator</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing Mfg.</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Jose L. Olmer</i>	14. MOTHER'S MAIDEN NAME <i>Regina Kroll</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>Miss Regina Olmer 12 Melvin Ave.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>2214</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Multiple Embolic Phenomenon</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i> Unknown			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <i>1/17</i> , 1957 to <i>6/17</i> , 1957, that I last saw the deceased alive on <i>6/17</i> , 1957, and that death occurred at <i>3:45 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Victor J. King</i> PHYSICIAN'S NAME (Type) <i>M.D.</i> ADDRESS <i>715 Frederick Ave</i> DATE SIGNED <i>6/17/57</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-20-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cathedral Cem.</i>	22d. LOCATION (City, town, or county) <i>Balto.</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Farley Funeral Home Catonsville Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>6-20-57</i>	24b. REGISTRAR'S SIGNATURE <i>D. L. L.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

JUN 29 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Item 12 6074 CERTIFICATE OF DEATH 060701  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN lb <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2113 Lorraine Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
3. NAME OF DECEASED (Type or print) <b>ROSARIO PAPALE</b>		d. STREET ADDRESS <b>169 Arunah Avenue</b>	
4. DATE OF DEATH <b>June 2nd., 1957</b>	Month <b>June</b>	Day <b>2nd.</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>2/21/1889</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman - Cement finishing work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>11. BIRTHPLACE (State or foreign country) Italy</b>	
12. CITIZEN OF WHAT COUNTRY <b>Italy</b>		13. FATHER'S NAME <b>GIUSEPPE PAPALE</b>	
14. MOTHER'S MAIDEN NAME <b>MARIA SALVO</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. <b>220-01-5740</b>		17. INFORMANT Address <b>2113 Lorraine Avenue Baltimore 7, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the underlying cause lost. <b>(b)</b>			
DUE TO <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 1957, to <b>6/2</b> , 1957, that I last saw the deceased alive on <b>6/2</b> , 1957, and that death occurred at <b>5 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. 3508 Park St, Baltimore 24, Md.</b> DATE SIGNED <b>6/4/57</b>			
ACTUAL SIGNATURE <b>Joseph Robert Salvo</b>			
PHYSICIAN'S NAME (Type) <b>JOSEPH ROBERT LIBERTO</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 6, 1957.</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Good Shepherd Cemetery</b>		22d. LOCATION (City, town, or county) <b>Ellicott City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons, Catonsville 28, Md.</b>		24. REG. & R. # REGISTRAR DATE <b>JUN 6 1957</b>	
ADDRESS <b>1400 E. 36th Street, Baltimore 24, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Miller</b>	

BUREAU V. S.

JUN 6 1957

RECEIVED

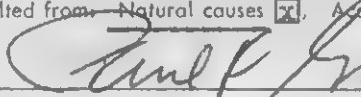
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06071

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your reference.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. LENGTH OF STAY IN b. <b>14</b>		d. STATE <b>Pennsylvania</b> b. COUNTY <b>Drexel Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>44 Gorsuch Road</b>		e. STREET ADDRESS <b>662 Drexel Brook Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>E. LEWIS</b>	First	Middle	Last	4. DATE OF DEATH <b>JUNE 4 1957</b>	Month Doy Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1895</b>	9. AGE (In years last birthday) <b>61</b>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dist. Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Warner Dental Mfg. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Vermont</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Robert Parry</b>		14. MOTHER'S MAIDEN NAME <b>Catherine (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Robert Cross, 44 Gorsuch Rd., Timonium, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Ruptured Aortic Aneurysm.</b> INTERVAL BETWEEN ONSET AND DEATH					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stealing the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL SEASIDE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6/4/57</b>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6-5-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Great Valley Presbyterian</b>	
22d. LOCATION (City, town, or county) <b>Malvern, Pa.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 6 '57	
				24b. REGISTRAR'S SIGNATURE 	

BUREAU V. S.

JUN 6 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6176 CERTIFICATE OF DEATH**

06072  
33

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armagost Nursing Home</b>		d. STREET ADDRESS <b>1707 E. Joppa Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>DOCK</b>	Middle <b>E.</b>	Last <b>PATRICK</b>
4. DATE OF DEATH	Month <b>June</b>	Day <b>14, 1957</b>	Year <b>19</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1867</b>
9. AGE (In years at birthday) <b>89</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
13. SEX 14. FATHER'S NAME <b>William Patrick</b>	15. MOTHER'S MAIDEN NAME <b>Nancy Stetzer</b>	16. SOCIAL SECURITY NO	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	18. IMMEDIATE CAUSE (a) <b>450.0</b>	19. INFORMANT <b>Family records</b>	Address
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.  DUE TO (b)  (c)		<b>Bronchial Pneumonia</b>  <b>Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 Days</b>  <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  <b>491X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m.      p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 9, 1957</b> to <b>June 14, 1957</b> that I last saw the deceased alive on <b>June 14, 1957</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles F. Dowdall M.D.</b> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <b>Charles F. Dowdall Talavera #401</b> DATE SIGNED <b>6/17/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 17, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Clark Sons</b>	ADDRESS <b>Towson, Md.</b>	24a. REC'D BY REGISTRAR <b>DATE 20 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mabel Grace</b>

Y. A. U. Y.

1951 NOV 1

REVIEW

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files or removed.

VS. ATSM(E) 5  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1835 S. Charles Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First George	Middle Clarence	Last Payne	4. DATE OF DEATH June 19	Month 19	Day Year 19 57
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1888		9. AGE (in years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John William			14. MOTHER'S MAIDEN NAME Rose Morgan				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT R' cords: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage  7040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Fractured skull  DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH  YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. allegedly fell and injured head about first of May, 1957 while entering his apartment.					
20c. TIME OF INJURY Hour o. m. unknown 5-2-57 19?		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Baltimore, Maryland (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE George M. Kieffer		DATE SIGNED 6-19-57					
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/21/57		22b. DATE THEREOF 6/21/57		22c. NAME OF CEMETERY OR CREMATORIUM Forest Cross		22d. LOCATION (City, town, or county) Bellevue Highway (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Faherty & Sons		ADDRESS 1818 L St. N.W.		24a. REC'D BY REGISTRAR JUN 20 '57		24b. REGISTRAR'S SIGNATURE John J. Faherty & Sons	

SAU V. A.

1957

EGEIVEL

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6078

## CERTIFICATE OF DEATH

06074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catoonsville</b>		c. LENGTH OF STAY IN lb <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie, Md.</b>		d. STREET ADDRESS <b>1040 Fitzallen Rd.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Sophie</b>	Middle <b>Ocens</b>	Last <b>Petrica</b>	4. DATE OF DEATH <b>June</b>	Month	Day <b>29</b>	Year <b>19 57</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1899</b>	9. AGE (in years last birthday) <b>78? yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Austria</b>				12. CITIZEN OF WHAT COUNTRY? <b>Austria</b>			
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>219-01-5283</b> INFORMANT Records: SPRING GROVE STATE HOSPITAL			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-sclerotic heart disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
400.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO							
(c) DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b> </b>			
20c. TIME OF INJURY Hour <b>a.m.</b>		Month <b>June</b>	Day <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b> </b>	20f. (City or town) <b> </b>	(County) <b> </b>
<b>p. m.</b>							(State) <b> </b>
21. I certify that I attended the deceased from <b>June 19, 1957</b> to <b>June 29, 1957</b> that I last saw the deceased alive on <b>June 25, 1957</b> and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b> </b> DATE SIGNED <b>CHARLES WARD</b> M.D. SPRING GROVE STATE HOSPITAL							
ACTUAL PHYSICIAN'S NAME (Type) <b>CHARLES WARD M.D.</b> Catoonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial July 3, 57</b>		22b. DATE THEREOF <b>July 3, 57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Cross Cemetery</b>		22d. LOCATION (City, town, or county) <b>Ridder Hwy Gaithersburg</b> (State) <b>Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard A. Finch, Jr. Bsns. Md.</b>				24a. REC'D BY REGISTRAR DATE JUL 2 '57 <b>Al Seach</b>			
				24b. REGISTRAR'S SIGNATURE			

RECEIVED  
FEB 19 1960

PUREAU V. S.

(5) MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 06075  
6/79 CERTIFICATE OF DEATH Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived) a. STATE <b>MARYLAND Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oatonsville</b>		c. LENGTH OF STAY IN 1b <b>58 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusing Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
f. STREET ADDRESS <b>610 Woodington Rd.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Alfred</b>	Middle <b>E. File</b>	Last 4. DATE OF DEATH <b>June 16/57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1879</b>
9. AGE (In years from last birthday) <b>78 yrs.</b>		F UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contracting Engineer-Colsolidated</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>France</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>-----Pile</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Wife,</b> <b>Bertha File</b>		Address <b>610 Woodington Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>177X</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>Multiple metastasis from carcinoma of prostate</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ----- (c)		DUE TO <b>prostate</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 5, 1955</b> , to <b>June 16, 1957</b> , that I last saw the deceased alive on <b>June 16, 1957</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4116 Edmondson Avenue</b> DATE SIGNED <b>George A. Knipp</b> <b>June 17, 1957</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>George A. Knipp, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation June 18/57</b>		22b. DATE THEREOF <b>June 18/57</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Crematory</b>		22d. LOCATION (City, town, or county) <b>Baltimore Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors, 4101 Edmondson</b>		24a. REC'D BY REGISTRAR DATE <b>Avg 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>D. L. Smith</b>	

BUREAU V. 8

JUN 17 1967

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06076

74

6180

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be referred by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please ~~same~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE	MD	b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
251 Lodgeston Baltimore		112		Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Forest Lodge Nursing Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		Fir	Middle	Last	4. DATE OF DEATH	Month Day Year	
MARY J. PONS					June - 17 -	1957	
5. SEX		COLOR OR RACE	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	DATE OF BIRTH	9. AGE (in years from birthday)	IF UNDER 1 YEAR Months Days Hours Min.	
Female White				May - 22 - 1896	6 yrs		
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
		Retail Distillery		Baltimore		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Edward Westervelt		Catherine East					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO		17. INFORMANT		Address	
No		214-22-0368		Helen C. Hunt - 102 Harvey St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Prostate Pneumonia				3 days	
331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO	Cerebral Accident				7 mos
(b)		DUE TO					
(c)		DUE TO					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
522X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 14, 1956, to June 17, 1957, that I last saw the deceased alive on June 17, 1957, and that death occurred at 1:00 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)				DATE SIGNED	
ACTUAL SIGNATURE James T. Means		M.D. 520 N. St. Balt. 19 Md.				6/18/57	
PHYSICIAN'S NAME (Type)		James T. Means					
22a. BURIAL/CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or County)	
Burial June 20, 1957				Balt. Cem.		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
John L. Farber		1030 N. Miller Ave 2431 E. Oliver St.		PATA 2		1957 Mason L. Farber	

RECEIVED  
BUREAU V. S.

JUN 25 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6/81

## CERTIFICATE OF DEATH

06077 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	c. LENGTH OF STAY IN 1b <i>Life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2918 Grindon La</i>		d. STREET ADDRESS <i>2918 Grindon La</i>	
3. NAME OF DECEASED (Type or print) <i>William John Reichart</i>	First <i>W</i>	Middle <i>J</i>	Last <i>H</i>
4. DATE OF DEATH <i>June 29</i>	Month <i>June</i>	Day <i>29</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR HAIR <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>22 April 1877</i>
9. AGE (In years last birthday) <i>80</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stone mason</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Reichart</i>		14. MOTHER'S MAIDEN NAME <i>Unk "Germany"</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>219034168</i>	
17. INFORMANT <i>Wife 2918 Grindon La.</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i> DUE TO <i>(c)</i> Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>None</i>		19b. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>10 p.m.</i>		20d. INJURY OCCURRED White Not white at work at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1953</i> to <i>June 1957</i> that I last saw the deceased alive on <i>May 1, 1957</i> and that death occurred at <i>1428 N. Harford Rd.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>9005 Harford Rd. 6/27/57</i>			
ACTUAL SIGNATURE <i>Frank T. Kaslik</i>		DATE SIGNED <i>1428 N. Harford Rd. 6/27/57</i>	
PHYSICIAN'S NAME (Type) <i>FRANK T. KASLIK JR.</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 29, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. John's Lutheran</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Rd. Balto. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lansley Funeral Home</i>		ADDRESS <i>7401 Belair Rd.</i>	
24a. REC'D BY REGISTRAR <i>DATE 11 1 1957</i>		24b. REGISTRAR'S SIGNATURE <i>John B. Basye</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGEAU V.

LL 1 1957

REGEAU E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6-182

## CERTIFICATE OF DEATH

060784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN TB <b>11 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>3327 Foster Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3327 Foster Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>FREDERICK</b>		First <b>A.</b>	Middle <b>REINSFELDER</b>	Lost	4. DATE OF DEATH <b>June 10</b>	Month <b>June</b>	Day <b>10</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>October 4, 1922</b>	9. AGE (In years lost birthday) <b>34 yrs.</b>	IF UNDER 1 YEAR Months <b>34</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>John A. Reinsfelder</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Schlee</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO. <b>218-14-6396</b>		17. INFORMANT <b>Clinical Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO HODGKIN'S DISEASE						INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)						<b>9 MONTHS</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>VA</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>XX</b>						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>VA</b>	(County) <b>VA</b>	(State) <b>VA</b>		
21. I certify that <input checked="" type="checkbox"/> attended the deceased from <b>May 31</b> , 1957, to <b>June 10</b> , 1957, <b>XXXXXX</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>6/10/57</b>		
ACTUAL SIGNATURE <i>Irving Freeman</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-13-57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sacred Hearts Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler, Inc., 103 South Wolfe Street,</b>		ADDRESS <b>Baltimore, Maryland</b>	24a. REC'D BY REGISTRAR <b>JUN 12 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Heironimus</b>			

RECEIVED  
BUREAU V.

112 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6183

## CERTIFICATE OF DEATH

06079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>229 Blakeney Road</b>		d. STREET ADDRESS <b>229 Blakeney Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>FRANK REMESCH</b>		First	Middle	Last	4. DATE OF DEATH <b>June 10 - 1957</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-8-1882</b>	9. AGE (In years last birthday) <b>74 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cabinet Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hochschild Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Joseph Remesch</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>214-01-2330</b>		17. INFORMANT <b>Frank S. Remesch..229 Blakeney Rd.</b>		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last.		Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		DUE TO (b)		Carcinoma of Stomach		1/2 yrs.		
DUE TO (c)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Sept. 15, 1953 to June 10, 1957</b> , that I last saw the deceased alive on <b>June 10, 1957</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1945 West Baltimore Street</b> DATE SIGNED <b>6/15/57</b>						
ACTUAL SIGNATURE <i>James R. Grabill</i>		PHYSICIAN'S NAME (Type) <b>JAMES R. GRABILL</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 14/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Gifford</i>		ADDRESS <b>1300 Eutaw Pl. 17</b>		24a. REC'D BY REGISTRAR <b>1</b>		24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>		

TO ATTEND: The law requires that the death certificate be executed within 24 hours after death. Logs 4 may be rendered by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 14 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06080

45

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Ida</b>	Middle <b>Elizabeth</b>	Last <b>Rice</b>
4. DATE OF DEATH	Month <b>June</b>	Day <b>23</b>	Year <b>19 57</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30, 1867</b>
9. AGE (In years last birthday) <b>90 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Richard Thomas Tydings</b>	14. MOTHER'S MAIDEN NAME <b>Mary Main</b>	Address <b>Charles Rice, 2126 Firethorne Rd. Middle River</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>420.0</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 21</b> , 1957, to <b>June 23</b> , 1957, that I last saw the deceased alive on <b>June 2</b> , 1957, and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7 P.M.</b>	DATE SIGNED <b>6/24/57</b>		
ACTUAL SIGNATURE <b>Robert J. Ryden</b>	M.D.		
PHYSICIAN'S NAME (Type) <b>ROBERT J. RYDEN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 26/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Dover Methodist Church Cemetery</b>	22d. LOCATION (City, town, or county) <b>Reisterstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe Street</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>6/27/57</b>	24b. REGISTRAR'S SIGNATURE <b>Edith Kurlage</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

UN - 2 1952

RECEIVED

## INSTRUCTIONS

**TO ATTEND:** PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 5-5 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 6985 CERTIFICATE OF DEATH

06081

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	Baltimore Catonsville	MARYLAND LENGTH OF STAY (in this place)	STATE Md CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Friendship
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS 1711 (If rural give location)		
<b>3. NAME OF DECEASED</b> (Type or Print)		(First) Albert S. (Middle) Ridgeley (Last)	<b>4. DATE OF DEATH</b> 6 21 1957
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 12-6-76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Stone Store	9. AGE last birthday 80 yrs.
		11. BIRTHPLACE (State or foreign country) Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charles W. Ridgeley		14. MOTHER'S MAIDEN NAME Ethel C. Ridgeley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Ethel M. Ridgeley - Post Mortem
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  250 X IMMEDIATE CAUSE (A) Bronchitis pneumonia ANTECEDENT CAUSE(S) DUE TO (B) Parkinsonism DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 3 da.  123d	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 471 X			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9 ~ 9, 1949, to 6 ~ 21, 1957, that I last saw the deceased alive on 6-21, 1957, and that death occurred at 3:30 P.M. from the causes and on the date stated above. SIGNATURE Wilmer K. Fullagar DATE SIGNED M.D. 6209 Frederick Ave., Balt. 28, Md. 6 21-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 6-24-57	NAME OF CEMETERY OR CREMATORIAL Mt. View
			LOCATION (City, town, or county) Sparrows Pt., Md.
24. REC'D BY REGISTRAR JUN 26 '57		REGISTRAR'S SIGNATURE Oberleach	25. FUNERAL DIRECTOR'S SIGNATURE Guttie H. Height
DATE			ADDRESS

**RECEIVED**

JUN 23 1957

**BUREAU V. S.**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 060823		
6086 CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2618 Linwood Ave					d. STREET ADDRESS 2618 Linwood Ave					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CATHERINE		First	Middle O	Last	4. DATE OF DEATH		Month JUNIE	Day 13	Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JAN 17-1892 68	9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) At Home					10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Rubeling					14. MOTHER'S MAIDEN NAME MARGARET KLoos							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. -		17. INFORMANT John Rubeling		Address 2618 Linwood Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-1 DUE TO Coronary thrombosis.										INTERVAL BETWEEN ONSET AND DEATH 5 minutes.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) DUE TO (c) lying cause lost.												
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Surgical accident 23 yrs ago.										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) BALTO.		(County)	(State)
21. I certify that I attended the deceased from 1945, 19, to June 13, 1957, that I last saw the deceased alive on June 11, 1957, and that death occurred at 9:20 M, from the causes and on the date stated above. ACTUAL SIGNATURE Harold H. Burns M.D. ADDRESS (Street, city or town, state) 8106 Harford Rd Maryland DATE SIGNED 6-14-57												
PHYSICIAN'S NAME (Type) Harold H. Burns												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4-15-57					22b. DATE THEREOF 4-15-57		22c. NAME OF CEMETERY OR CREMATORIUM SCHWARTZ CEM		22d. LOCATION (City, town, or county) BALTO		(State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES F. EVANS & SON					ADDRESS 118 W ME. ROYAL AVE		24a. REC'D BY REGISTRAR JUN 17 1957		24b. REGISTRAR'S SIGNATURE Dr. A. M. Burns			

BUREAU V.

NOV 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 18. Film 218  
**5942 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06983

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 53 Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 117 Main Street		d. STREET ADDRESS 117 Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First LUCIOUS	Middle	Last ROBINSON	4. DATE OF DEATH June 16 19 57	Month Day Year
--	---------------	--------	---------------	-----------------------------------	----------------

5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2/28/47	9. AGE (in years last birthday) 53 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
----------------	-----------------------------	---	-----------------------------	---	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Carolina S.A.	10c. BIRTH PLACE (State or foreign country) S.C.	12. CITIZEN OF WHAT COUNTRY?
--	--	---	------------------------------

13. FATHER'S NAME LUCIOUS ROBINSON	14. MOTHER'S MAIDEN NAME Anna Kistley
---------------------------------------	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 249-10-4526	17. INFORMANT Address
--	--	--------------------------

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease	
DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	
DUE TO	
(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)
---	---

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
---	------------------------	---	--	--

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
---	--	--	--	--	--

ACTUAL	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 6/17/57
--------	---	------------------------

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 22-57 Eastley S.C.	22b. DATE THEREOF ADDRESS	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS	22d. LOCATION (City, town, or county) (State)
---	------------------------------	---	--

FUNERAL DIRECTOR'S SIGNATURE Robert E. Williams 1701 N. Bond St.	24d. REC'D BY REGISTRAR DATE 7/1/57	REGISTRAR'S SIGNATURE Tom Kelly
---	--	------------------------------------

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certifying physician. Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

BRUNAU V. S.

11. 3. 1957

REGELIVE

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6087 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06084

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar. File 4 to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>47 BELFAST RD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CALVIN</b>		First <b>A.</b> Middle <b>RODGERS</b> Last	4. DATE OF DEATH Month <b>6</b> Day <b>25</b> Year <b>1957</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>5-5-84</b>	9. AGE (in years last birthday) <b>73 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLASTERER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. <b>215-03-8727</b>	17. INFORMANT Address <b>GENEVA RODGERS 49 OAKWAY RD</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Charles F O'Donnell</i>		DATE SIGNED <i>6/25/57</i>	
EXAMINER'S NAME (Type) <i>Charles F O'Donnell</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-28-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>MTZION</b>
22d. LOCATION (City, town, or county) <b>BALTO CO.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Paul E Lehman 360 Chestnut Ave</i>		ADDRESS	
		24a. REC'D BY REGISTRAR <b>JUN 27 '57</b>	24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

RECEIVED  
BUREAU V. S.

JUN 20 1968

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 1  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 06085
6088 CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>					2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Md.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b>					b. COUNTY <b>Baltimore City</b>
c. LENGTH OF STAY IN lb <b>4 1/2 mo.</b>					d. STREET ADDRESS <b>2916 Hartford Rd.</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <b>Otto</b>	Middle <b>Julius</b>	Last <b>Rose Jr.</b>	4. DATE OF DEATH	Month <b>6</b>	Day <b>14</b>	Year <b>1957</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/4/1901</b>	9. AGE (In years last birthday) <b>56 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Salesmen</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>			11. BIRTHPLACE (State or foreign country) <b>Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otto J. Rose</b>			14. MOTHER'S MAIDEN NAME <b>Georgina Reisinger</b>			Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16. SOCIAL SECURITY NO <b>None</b>			17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far Advanced Pulmonary Tuberculosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>11 yrs.</b>
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1/29</b> , 19 <b>57</b> , to <b>6/14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/14</b> , 19 <b>57</b> , and that death occurred at <b>6:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Maryland</b>										DATE SIGNED
ACTUAL SIGNATURE <b>William Newcomer</b> M.D. Mt. Wilson, Maryland										
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Parkwood Cemetery</b>			22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>					ADDRESS <b>5095 Hartford Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>6/18/57</b>		24b. REGISTRAR'S SIGNATURE <b>Dorothy Newbold</b>	

RECEIVED  
BUREAU V. S.

JUN 10 1957

RE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06086

6089

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b <b>147 Range Rd.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Holaburgo</b>		d. STREET ADDRESS <b>4501 Ridge Ave.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ALICE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>F.</b>	Middle <b>RULLMAN</b>	Last <b>June</b>	4. DATE OF DEATH <b>6, 1957</b>	Month <b>June</b>	Day <b>6</b>	Year <b>1957</b>
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 12, 1876</b>		9. AGE (In years last birthday) <b>80 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never employed</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>D. C.</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Frederick Rullman</b>		14. MOTHER'S MAIDEN NAME <b>Alice V. Elliott</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>no</b>		Address <b>Miss Edna E. Rullman - 4501 Ridge Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Massive Myocardial Infarction				INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>6/15</b> , 1957, to <b>6/16</b> , 1957, that I last saw the deceased alive on <b>6/6</b> , 1957, and that death occurred at <b>10 AM</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, post office)		
ACTUAL SIGNATURE <b>W. M. Smith</b>		M.D.		<b>6305 1/2 Monroe St.</b>		DATE SIGNED <b>6/16/57</b>		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto., Md.</b>		(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Schucker &amp; Sons</b>		ADDRESS <b>Balto. 17</b>		24a. REC'D BY REGISTRAR DATE <b>6/13/57</b>		24b. REGISTRAR'S SIGNATURE <b>Robert J. Schucker</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JUN 11 1957

RECEIVED

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18  
6090 CERTIFICATE OF DEATH**

06087

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Balto.</i>		MARYLAND <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN lb <i>1 week</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>17 Overbrook Rd.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
3. NAME OF DECEASED (Type or print)		First <i>Lillie</i>	Middle <i>M. Sawyer</i>
4. DATE OF DEATH		Month <i>June</i>	Day <i>13</i> Year <i>1957</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Female		white	B. DATE OF BIRTH <i>Aug. 6. ?</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Balto.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Sawyer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Ann Schley</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Not no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT		Address <i>Mrs. Peddicord - 17 Overbrook Rd</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>	
L22.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Myocardial degeneration</i>			
(b) DUE TO <i>Arteriosclerotic Cardiac Vacular Disease</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Sensitivity</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>Balto.</i>	
21. I certify that I attended the deceased from <i>December</i> , 1956, to <i>June 13</i> , 1957, that I last saw the deceased alive on <i>June 13</i> , 1957, and that death occurred at <i>3:15 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>D. C. MacLaughlin</i>		ADDRESS (Street, city or town, state) <i>4508 Edmondson Village</i>	
PHYSICIAN'S NAME (Type) <i>D. C. MacLaughlin</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 17, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Lawson Park</i>		22d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury</i>		ADDRESS <i>6411 Windsor Mill Rd.</i>	
		24a. REC'D BY REGISTRAR <i>JUN 18 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>John T. Stansbury</i>	

RECEIVED

BUREAU V. S.

JUN 18 1955

100-12345

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06088

6091

## CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 v o l - 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Airmacost Nurs. Ho. 812 Regester Ave.				d. STREET ADDRESS 300 Goodwood Gardens		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANNE	Middle HOGE	Last Savage	4. DATE OF DEATH Jun 29	Month Jun	Day 29	Year 1957
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 18, 1875	9. AGE (in years lost birthday) 81 yrs	10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (rtd)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D. C.		12. CITIZEN OF WHAT COUNTRY? Md.	
13. FATHER'S NAME Wm. Schofield Hoge				14. MOTHER'S MAIDEN NAME Mary Barlow Stearns			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Frederick A. Savage, Jr. - Cockeysville,		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> DUE TO <i>Generalized Arteriosclerosis</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>8 Days</i> (c) <i>10 yrs</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  20c. TIME OF INJURY Month, Day, Year Hour o. m. 20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/> p. m. 19 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>July 21</u> , 1957, to <u>June 29</u> , 1957, that I last saw the deceased alive on <u>June 29</u> , 1957, and that death occurred at <u>11:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles F O'Donnell, M.D. 7501 York Rd 77157 DATE SIGNED ACTUAL SIGNATURE CHARLES F O'DONNELL, M.D. 7501 YORK RD 77157 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/3/57	22c. NAME OF CEMETERY OR CREMATORIUM Lakewood Cem.		22d. LOCATION (City, town, or county) Cooperstown, N.Y.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Dickner & Sons - Baileys ADDRESS		24a. REC'D BY REGISTRAR DATE 7/2/57		24b. REGISTRAR'S SIGNATURE Mabel Hayes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILZAU V. A.

3 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06089

6092

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	c. LENGTH OF STAY IN 1b 18 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice		d. STREET ADDRESS 1041 Hillen Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frank	Middle Henry	Last Schepher
4. DATE OF DEATH	Month JUNE	Day 20	Year 1957
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1881
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Schepher		14. MOTHER'S MAIDEN NAME Augustas Kruger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 215-10-9505	
17. INFORMANT Admission Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		INTERVAL BETWEEN ONSET AND DEATH 60 days Arteriosclerosis - Generalized 10 yrs	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 6</u> , 1957, to <u>June 19</u> , 1957, that I last saw the deceased alive on <u>June 19</u> , 1957, and that death occurred at <u>12:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE CHARLES F. O'DONNELL M.D. 7501 YORK RD 6/10/57 PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1957	22c. NAME OF CEMETERY OR CREMATORIUM Holy Redeemer
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Linnane		24a. REC'D BY REGISTRAR DATE 2157	24b. REGISTRAR'S SIGNATURE D. E. Linnane

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. A.

JUN 21 1957

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pgge 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06090
Item 17: G217 6-28-57 L. CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. LENGTH OF STAY IN 1b 25yr8mth9dys			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL					d. STREET ADDRESS 805 N. Montford St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First Bruno	Middle C	Last Schramm	4. DATE OF DEATH June 21 1957	Month June	Day 21	Year 1957		
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 1898 - 12/25	8. AGE (In years last birthday) 58? yrs	9. IF UNDER 1 YEAR Months 0	Days 0	IF UNDER 24 HRS Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist			10b. KIND OF BUSINESS OR INDUSTRY Ge many			11. BIRTHPLACE (State or foreign country) N.Y. 1911 AD 1911 29/1957/citizen				
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown			Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type no. or unknown) unknown			16. SOCIAL SECURITY NO unkrown			17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) Arteriosclerotic cardiovascular disease } (c)										INTERVAL BETWEEN ONSET AND DEATH
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 422.1			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from June 7, 1957, to June 21, 1957, that I last saw the deceased alive on June 21, 1957, and that death occurred at 10:30a.m. from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Stella Wachler, M.D. DATE SIGNED 6-21-57
ACTUAL SIGNATURE Stella Wachler, M.D.										
PHYSICIAN'S NAME (Type) Stella Wachler, M.D.										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-57		22c. NAME OF CEMETERY OR CEMETARY Holy Redeemer			22d. LOCATION (City, town or county) Baltimore Md			
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 805 Montford Rd		24a. RECEIVED BY DATE			24b. REGISTRAR'S SIGNATURE Aut. L. Ruck			

RECEIVED  
PERREAU Y.

JUN 24 1957

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## 6094 CERTIFICATE OF DEATH

07241

Reg. Dist. No. 40

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Upper Falls	c. LENGTH OF STAY IN 1b  Lifetime	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  x2 Upper Falls	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First John W.	Middle Schutz
4. DATE OF DEATH	Month June	Day 14	Year 1957
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 28 1872
9. AGE (in years on birthday) 95 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Home Construction	
10c. BIRTHPLACE (State or Foreign country) Upper Falls, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Frederick J. Schutz		14. MOTHER'S MAIDEN NAME Annie E. Orem	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Evelyn E. Schutz, Upper Falls, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 11222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Walter M Hammatt BALDWIN June 16 1957 PHYSICIAN'S NAME (Type) Walter M Hammatt BALDWIN June 16 1957			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 16, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Franklin Presbyterian		22d. LOCATION (City, town, or county) Franklinville, Balto., Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard M. Gandy Abingdon Md.		24a. REC'D. BY REGISTRAR DATE 6/17/57	
		24b. REGISTRAR'S SIGNATURE Walter M Hammatt	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

APR 22 1957

06091  
31

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE Md.

b. COUNTY Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

West Liberty Rd

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

West Liberty Rd

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

e. IS RESIDENCE  
ON A FARM?  
YES  NO

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

5. SEX

M

6. COLOR OR RACE

Col

7. MARRIED  NEVER MARRIED

WIDOWED  DIVORCED

8. DATE OF BIRTH

7/22/57

9. AGE (In years  
less birthday)  
— yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

12. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

house

10b. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

New York, N.Y.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Elaine Norman Sutton

14. MOTHER'S MAIDEN NAME

Jessie Shaw

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

—

17. INFORMANT

Young Shaw, White Hall, N.Y.  
Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY,  
IMMEDIATE CAUSE (a)

4.0

DUE TO

Conditions, If any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20c. TIME OF INJURY  
Hour a.m. p.m.

20d. INJURY OCCURRED  
While at work  Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

Month, Day, Year  
19

20f. (City or town)  
(County) (State)

(New York City)

(New York)

BUREAU V. S.

JUN 98 1997

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the Funeral Director, page 3 should detach for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6096

## CERTIFICATE OF DEATH

06002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard, Maryland</b>		c. LENGTH OF STAY IN 1b <b>46 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2506 Poplar Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>WELFORD</b>	Middle D.	Last <b>SHELHOSS</b>	4. DATE OF DEATH <b>Jan. 20, 1895</b>	Month <b>June</b>	Day <b>8</b>	Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1895</b>	9. AGE (In years lost birthday) <b>62 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Shelhoss</b>		14. MOTHER'S MAIDEN NAME <b>Mary Davis</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 213-03-9124</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>155 X CARCINOMATOSIS OF THE OMENTUM, MESENTERY AND ABDOMINAL WALL</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>ADENOCARCINOMA OF GALL BLADDER</b>						UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>VAH, FORT HOWARD, MARYLAND</b>	(County) <b>Woodlawn, Md.</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>April 23, 1957</b> , to <b>June 8, 1957</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Loring Byers Funeral Home, 8728 Liberty Rd.</b>		DATE SIGNED <b>6/10/57</b>	
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		M.D.					
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M. D.</b>		VAH, FORT HOWARD, MARYLAND				6/9/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-12-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Woodlawn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers Funeral Home, 8728 Liberty Rd.</b>		ADDRESS <b>Baltimore, Md.</b>		24a. REC'D BY REGISTRAR <b>6/10/57</b>		24b. REGISTRAR'S SIGNATURE <i>Howard J. Fleischman</i>	

RECEIVED  
BUREAU V. S.

1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4

06093

6097

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
<i>Baltimore</i> <i>MARYLAND</i>		<i>Md</i> <i>b. COUNTY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Pikesville</i>		<i>Pikesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION	d. STREET ADDRESS		
<i>2407 Light Foot Drive</i>	<i>2407 Light Foot Drive</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>-SHEISINGER</i>	Last <i>84</i>
4. DATE OF DEATH	Month <i>June</i>	Day <i>29</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 1900</i>
9. AGE (In years (In months) <i>84</i> ) yrs	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Russia</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Johansen</i>	14. MOTHER'S MAIDEN NAME <i>Etta</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Stanley Babine - same</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Acute myocardial infarction 10 days arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>6/18, 1957, to 6/29, 1957, that I last saw the deceased alive on 6/28, 1957, and that death occurred about 3 P.M., from the causes and on the date stated above.</i>		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>2320 Eutaw Place</i>
21. I certify that I attended the deceased from 6/18, 1957, to 6/29, 1957, that I last saw the deceased alive on 6/28, 1957, and that death occurred about 3 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Milton B. Kirsh, M.D.</i>			
DATE SIGNED <i>Milton B. Kirsh, M.D.</i>			
ACTUAL SIGNATURE <i>Milton B. Kirsh, M.D.</i>		PHYSICIAN'S NAME (Type) <i>Milton B. Kirsh</i>	
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-1-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore Hebrew</i>	22d. LOCATION (City, town, or county) <i>Baltimore Md</i>
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc 2100 Eutaw Place</i>	22f. ADDRESS <i>2100 Eutaw Place</i>	24a. REC'D BY REGISTRAR DATE <i>2 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Milton Kirsh</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REFUGEE

RECEIVED  
BY THE  
REFUGEE

REFUGEE  
RECEIVED  
BY THE  
REFUGEE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6098

## CERTIFICATE OF DEATH

06094

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician and completely filled in by the funeral director. To this certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with page 3 should be detached for use as the burial, cremation, or removal, and in any event within 72 hours after death. The registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE			
Baltimore MARYLAND		Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Rural Anneslie	28 yrs	Anneslie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS				
602 Anneslie Rd.	602 Anneslie Road				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
MATTHEW	JAMES		SMITH, SR		
4. DATE OF DEATH	Month	Day	Year		
June	8	1957			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct 15, 1895	61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
agent		Internal Revenue		Baltimore U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Matthew James Smith		Unknown		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address	
No		212-03-8339		Mrs. Katherine E. Smith - Same.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PULMONARY EDEMA 1 DAY			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) ACUTE MYOCARDIAL INFARCTION			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from on JUNE 8, 1957, to _____, 19_____, that I last saw the deceased alive on JUNE 8, 1957, and that death occurred at 8:45 PM, from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
DATE SIGNED					
ACTUAL SIGNATURE					
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL	
Burial		6/12/57		Harr. Rec.	
22d. LOCATION (City, town, or county)		(State)			
22d. LOCATION (City, town, or county)		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	
Henry W. Leckie 4925 York Rd.				DATE 6/10/57	
24b. REGISTRAR'S SIGNATURE					
24b. REGISTRAR'S SIGNATURE					

RECEIVED  
MAY 11 1957

BUREAU V. E.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6099 CERTIFICATE OF DEATH

06095

Reg. Dist. No.

HOSPITAL OR ATTENDING PHYSICIAN: File I am required that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>120 Maiden's Choice Lane</b>				d. STREET ADDRESS <b>120 Maiden's Choice Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>MILDRED</b>		First <b>R.</b>	Middle <b>SNIBBE</b>	Last	4. DATE OF DEATH Month <b>June 19,</b>	Day <b>19</b>	Year <b>57</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1878</b>		9. AGE (In years from birthdate) <b>78 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Vt.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Port Washington, N.Y.</b>				
13. FATHER'S NAME <b>Benj. F. Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Georgianna Fiske</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Robert M. Snibbe - 14 Hillside Ave.</b>		Add. <b>Port Washington, N.Y.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Metastatic Carcinoma of Intestines</i>				INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		<i>Ca of Cancer</i>				<b>18 mos.</b>				
DUE TO (c)										
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour—o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>July 1, 1942</b> to <b>June 19, 1957</b> , that I last saw the deceased alive on <b>June 17, 1957</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>6205 Frederick Ave., Baltimore 28, Md.</b>	DATE SIGNED <b>6-20-57</b>	
ACTUAL SIGNATURE <i>Walter K. Gallagher</i>		M.D.								
PHYSICIAN'S NAME (Type) <b>Walter K. Gallagher</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. J. Pickering &amp; Sons</i>		ADDRESS <b>Baltimore 17, Md.</b>						24b. REG'D BY REGISTRAR DATE <b>JUN 25 '57</b>		
								24b. REGISTRAR'S SIGNATURE <i>John J. Pickering</i>		

BUREAU V. S.

JUN 23 1957

KELLOGG & FU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

57  
6096

6100

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Ma.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Owings Mills</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Owings Mills</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Franklin Lane</i>		STREET ADDRESS <i>Franklin Lane</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>John</i>	(Middle) <i>W.</i>	(Last) <i>Sprinkel</i>
4. DATE OF DEATH	(Month) <i>June</i>	(Day) <i>26</i>	(Year) <i>1957</i>
5. SEX	6. COLOR OR RACE <i>M W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>March 13, 1897</i>
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Inspector</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Aviation</i>	12. BIRTHPLACE (State or foreign country) <i>Elmwoodenburg, Md</i>
13. FATHER'S NAME <i>Charles Wesley Sprinkel</i>	14. MOTHER'S MAIDEN NAME <i>Anna Grace Utz</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service <i>Yes 1917 215-07-4894</i>	16. SOCIAL SECURITY NO. <i>17-215-07-4894</i>
17. INFORMANT <i>Wife Mrs. Ruth Sprinkel</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>1. Immediate cause <i>Coronary thrombosis</i></p> <p>2. Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Arteriosclerotic C.V.D.</i></p>			
III. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>D 4x11</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>9 Dec</i> , 1950, to <i>26 June</i> , 1957, that I last saw the deceased alive on <i>25 May</i> , 1957, and that death occurred at <i>5:20 A.M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>Charles H. Williams, M.D.</i>		ADDRESS <i>Pikeville 8, Md</i>	
DATE SIGNED <i>26 June '57</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>June 29, 1957</i>	NAME OF CEMETERY OR CREMATORIAL <i>St. Thomas</i>
LOCATION (City, town, or county) <i>Owings Mills, Md.</i>		(State)	
DATE REC'D BY LOCAL REG. <i>June 27, 1957</i>		REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>	24. FUNERAL DIRECTOR ADDRESS <i>J.F. Eline &amp; Sons, Reisterstown, Md.</i>

RECEIVED  
BUREAU V. S.

JUL 2 1952

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6191

## CERTIFICATE OF DEATH

06097

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
 page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 of 2 should be filed with  
 the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>13 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X2 Baltimore</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>4306 Wilkens Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Rebecca Grove</b>		First	Middle	Last	4. DATE OF DEATH <b>June 25,</b>	Month	Day	Year <b>19 57</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>1859? May 31 st. 97 98</b>	9 AGE (In years last birthday) <b>97 98</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				
13. FATHER'S NAME <b>George Fowler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Unknown</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address				
NO										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Acute cardiac failure								
DUE TO (b)		Arteriosclerotic cardiovascular disease								
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore Md.</b>		(County) <b>Baltimore Md.</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>June 12, 1957</b> , to <b>June 25, 1957</b> , that I last saw the deceased alive on <b>June 25, 1957</b> , and that death occurred at <b>7:15 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1300 Eutaw Pl. 17</b>							DATE SIGNED <b>6-25-57</b>	
ACTUAL SIGNATURE <i>Stella Wachsler</i>		M.D. SPRING GROVE STATE HOSPITAL								
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 27/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>		(State) <b>Md.</b>		
22e. FUNERAL DIRECTOR'S SIGNATURE <i>J. R. Wachsler</i>		ADDRESS <b>1300 Eutaw Pl. 17</b>		24a. REC'D BY REGISTRAR <b>JUN 27 '57</b>		24b. REGISTRAR'S SIGNATURE <i>Altheidech</i>				
VS A15 (4) 1SM 9/55										

RECEIVED  
BUREAU V. A.

JUN 22 1972

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5946

## CERTIFICATE OF DEATH

06098

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
<i>Baltimore County Maryland</i>		<i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Baltimore</i>		<i>5 mos.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) e. INSTITUTION		d. STREET ADDRESS	
<i>28 Fourth Ave</i>		<i>2626 St. Benedict St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>John S. Strube</i>		<i>John</i>	<i>S.</i>
4. DATE OF DEATH		Month	Day
<i>June 17-1957</i>		<i>June</i>	<i>17</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH
<i>Male</i>		<i>White</i>	<i>Oct. 21-1888</i>
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	9. AGE (In years lost birth 68 yrs)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Salvager</i>		<i>Dept. Store</i>	
10c. BIRTHPLACE (State or foreign country)		11. CITIZEN OF WHAT COUNTRY?	
<i>Baltimore, Md U.S.A.</i>		<i>Baltimore, Md U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>John S. Strube</i>		<i>Margaret Need</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>816-18-8747</i>	
17. INFORMANT		Address	
<i>John S. Strube - 28-Fourth-Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Carcinoma, stomach with generalized abdominal metastases</i>	
151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		<i>9 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Aug</i> , 1926, to <i>June 17, 1957</i> , that I last saw the deceased alive on <i>June 10, 1957</i> , and that death occurred at <i>2:15 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		<i>P. Arthur Rossberg MD 2436 Washington Blvd Baltimore, Md.</i>	
PHYSICIAN'S NAME (Type)		<i>DATE SIGNED 6/17/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial</i>		<i>6/19/57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
<i>Towson Park</i>		<i>Baltimore, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<i>J. K. Lippert - Nec Estate Place</i>		<i>JUN 20 1957</i>	
		24b. REGISTRAR'S SIGNATURE	
		<i>D. E. M. T. M.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEAU V. A.

NY 1957

REGELVÉD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page **1**  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												06099 <i>4c</i>		
6102 CERTIFICATE OF DEATH												Reg. Dist. No.		
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>						2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>			c. LENGTH OF STAY IN lb <b>30 Minutes</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			d. STREET ADDRESS <b>2827 Topaz Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>														
3. NAME OF DECEASED (Type or print)		First <b>CARL</b>	Middle <b>L.</b>	Last <b>TAYLOR</b>	4. DATE OF DEATH <b>June 10 1957</b>		Month <b>June</b>	Day <b>10</b>	Year <b>1957</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1920</b>		9. AGE (In years last birthday) <b>37 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Office Clerk</b>			10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>Cork &amp; Seal Factory Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>								
13. FATHER'S NAME <b>Carl Taylor</b>					14. MOTHER'S MAIDEN NAME <b>Nell Maderia</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>WW II</b>			17. INFORMANT <b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOCARCINOMA, LEFT LUNG</b>												INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>		
162-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m. _____			20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
VA 12:15 PM 21. I certify that I attended the deceased from June 10, 1957, to June 10, 1957, and that death occurred at 12:15 PM, from the causes and on the date stated above.												ADDRESS (Street, city or town, state)		
												DATE SIGNED <b>6/10/57</b>		
ACTUAL SIGNATURE <i>Chien Wei Lan</i>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>												
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>6-13-57</b>			22c. NAME OF CEMETERY OR CREMATORIAL <b>8910. N.Y. f</b>			22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard Buck Funeral Home, 5305 Harford Rd., Baltimore 14, Md.</b>			ADDRESS <b>11</b>			24a. REC'D BY REGISTRAR <b>JUN 12 1957</b>			24b. REGISTRAR'S SIGNATURE <i>Leonard L. Farley</i>					

BUREAU V. 8

1-13 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## : 6103 CERTIFICATE OF DEATH

06100

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8420 Greenway Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Elizabeth</b>	Middle <b>M.</b>	Last <b>Taylor</b>
4. DATE OF DEATH	Month <b>June</b>	Day <b>29</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19, 1890</b>
9. AGE (In years last birthday) <b>66 yrs.</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS <b>Days</b>	12. IF UNDER 24 HRS <b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY <b>Ireland</b>	
13. FATHER'S NAME <b>James Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Duff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT <b>Mr. Joseph Peverill</b>	Address <b>8420 Greenway Rd.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>170x</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		DUE TO <b>Generalized Carcinomatosis 4 mo</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>4 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 17, 1957</b> to <b>June 27, 1957</b> that I last saw the deceased alive on <b>June 28, 1957</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8400 Loch Raven Blvd., Baltimore, Md.</b>	
ACTUAL SIGNATURE <i>Joseph F. Li Pira</i>	DATE SIGNED <b>6/27/57</b>		
PHYSICIAN'S NAME (Type) <b>Joseph F. Li Pira</b>	M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 2, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Moreland Mem. Park</b>	22d. LOCATION (City, town, or county) <b>Taylor Ave.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook-Towson, Inc.</b>		ADDRESS <b>1050 York Rd.</b>	24a. REC'D BY REGISTRAR DATE <b>1 1957</b>
			24b. REGISTRAR'S SIGNATURE <b>Patricia Hayes</b>

BUREAU V. E.

L.O. 1957

RECEIVED

1

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>											
<b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>											
6104 06101 Reg. Dist. No. 38											
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
<i>Baltimore</i> MARYLAND				a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>Towson</i>		<i>6 hrs.</i>		<i>Parkville</i>		<i>8703 Richmond Rd</i>					
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)											
<i>Board of Education - High School</i>											
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year			
<i>RAYMOND BASIL TEIXEIRA</i>					JUNE	27		1957			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR			IF UNDER 24 HRS.			
<i>MALE</i>	<i>WHITE</i>	<i>WIDOWED</i> <input type="checkbox"/>	<i>JUNE 19, 1927</i>	<i>32</i> yrs.	Months	Days		Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
<i>PSYCHOLOGIST</i>				<i>BOARD OF EDUCATION</i>				<i>NEW YORK</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				12. CITIZEN OF WHAT COUNTRY?			
<i>Anthony Teixeira</i>				<i>Margaret Turney</i>				<i>USA</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>YES</i>				16. SOCIAL SECURITY NO.				17. INFORMANT			
(If yes, give name and rank or date of service) <i>WW II</i>				<i>087-18-4136</i>				<i>FAMILY RECORDS</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.1</i> DUE TO <i>Coronary thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____											
(c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c TIME OF INJURY		Month, Day, Year	Hour	a. m.	b. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
			19								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Charles F O'Donnell</i> DATE SIGNED <i>6/27/57</i>											
EXAMINER'S NAME (Type) <i>Charles F O'Donnell</i>											
22a BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
<i>CREMATION</i>		<i>JULY 1, 1957</i>		<i>ARLINGTON NATL CEM.</i>		<i>ARLINGTON, VIRGINIA</i>					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
<i>John Burns Son, Towson, Md.</i>				<i>July 1, 1957</i>		<i>Mabel C. Gray</i>					
VS. A15ME(S) 5M 9/55											

Y. A. V. U. AVAIL

3 1957

DEALERS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6105 CERTIFICATE OF DEATH

06102

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Baltimore</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Chesapeake, Maryland</i>		<i>Baltimore City</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>Saintly Work Home</i>		<i>14313 Baltimore St 17</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>Jane Couture</i>		<i>Thomas</i>	<i>Thomas</i>
4. DATE OF DEATH		Month	Day
<i>June 16</i>		<i>June</i>	<i>16</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
<i>Female</i>		<i>White</i>	<i>Never</i>
8. DATE OF BIRTH		9. AGE (In years from birthday) IF UNDER 1 YEAR, MONTHS yrs. - months - days - hours - min.	10. IF UNDER 24 HRS. Months - Days - Hours - Min.
<i>Apr 10, 1917</i>		<i>79 yrs. - 3 months - 16 days - 12 hours - 0 min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Housewife</i>		<i>None</i>	
10c. BIRTHPLACE (State or foreign country)		11. CITIZEN OF WHAT COUNTRY?	
<i>South Carolina</i>		<i>U.S.</i>	
12. FATHER'S NAME		13. MOTHER'S MAIDEN NAME	
<i>James F. Thomas</i>		<i>Annie Thomas</i>	
14. MOTHER'S MAIDEN NAME		Address	
<i>Annie Thomas</i>		<i>1124 Lafayette St</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>No</i>		<i>NO</i>	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
		<i>Arteriosclerotic cardiovascular renal disease</i>	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH <i>1 yrs +</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)	
DUE TO		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
		<i>Baltimore, Md. Baltimore Co. Maryland</i>	
21. I certify that I attended the deceased from <i>13 June</i> , 1957, to <i>16 June</i> , 1957, that I last saw the deceased alive on <i>15 June</i> , 1957, and that death occurred at <i>1:35 A.M.</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>118 St Paul St.</i> DATE SIGNED <i>John A. Nesbit Jr.</i>	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
<i>John A. Nesbit Jr.</i>		<i>John A. Nesbit Jr.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Burial June 16, 1957</i>		<i>22c. NAME OF CEMETERY OR CREMATORIAL</i>	
		<i>St. Stephen's Cemetery - S.C.</i>	
22d. LOCATION (City, town, or county)		(State)	
<i>Baltimore, Maryland</i>		<i>S.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE:		ADDRESS	
<i>John A. Nesbit Jr.</i>		<i>108 W. 10th Street</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <i>June 18, 1957</i>		ADDRESS <i>Baltimore, Maryland</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please mail carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU Y.

JUN 18 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 06103 44			
6106 CERTIFICATE OF DEATH													
1. PLACE OF DEATH o COUNTY <b>Baltimore</b>					MARYLAND					2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>					c. LENGTH OF STAY IN 1b <b>53 Days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1649 Argonne Drive, Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>										d. STREET ADDRESS <b>1649 Argonne Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First <b>HARRY</b>		Middle <b>O.</b>		Last <b>THUMA</b>		4. DATE OF DEATH <b>June 28</b>		Month <b>June</b>	Day <b>28</b>	Year <b>1957</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 12, 1897</b>		9. AGE (in years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>					11. BIRTHPLACE (State or foreign country) <b>Baltimore County, Maryland U. S. A.</b>			
13. FATHER'S NAME <b>John P. Thuma</b>					14. MOTHER'S MAIDEN NAME <b>Clara M. Kidd</b>					12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO <b>717-07-8382</b>					17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF THE RECTUM, WITH METASTASES</b>										INTERVAL BETWEEN ONSET AND DEATH <b>18 MONTHS</b>			
104X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) _____ DUE TO (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Hour o. m p. m		Month <b>19</b>	Doy. <b>VA</b>	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Maryland</b>	(State) <b>MD</b>	
21. I certify that I attended the deceased from May 6, 1957, to June 28, 1957.										DATE SIGNED			
XIXXXXXXX and that death occurred at 2:30 A.M. from the causes and on the date stated above.										ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>Armen Bogosian</i>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>								<b>6/28/57</b>			
PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSTAN, M.D.</b>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn Cemetery</b>				22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Blight Inc.</b>		ADDRESS <b>Wm Cook Blight, Inc., 6009 Harford Rd., Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>195</b>		24b. DATE <b>195</b>		25. REGISTRAR'S SIGNATURE <i>Jaworski, Fabby</i>					
VS AIS (4) 1SM 9/55													

BUREAU V. A.

JUL 2 1965

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After the physician or attending physician has been retained by the hospital or attending physician, he shall file the death certificate with the registrar within 72 hours after death. After the death certificate has been executed by the attending physician and completely filled in by the funeral director, he shall file it in the office of the registrar.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed in by the attending physician and completely filled in by the funeral director, the copy of this death certificate assembly should be detached for use as a burial permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06104

6107

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	COUNTY 3817 Arbutus Ave Lockearn
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Elizabeth S. B. Tinkley		June 6 1957	
5. SEX F.	6. COLOR OR RACE W.R.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W.	8. DATE OF BIRTH Sept 12 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Henry B. Tyson		11. BIRTHPLACE (State or foreign country) Frederick Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Carcinoma of the bowel with metastasis to the lungs</i>			
ANTECEDENT CAUSE(S) DUE TO (B) _____			
DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-7, 1957, to 6-6, 1957, that I last saw the deceased alive on 6-4, 1957, and that death occurred at 6 P.M., from the causes and on the date stated above. SIGNATURE <i>C. Herbert Mueller</i> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial June 9, 1957</i>		DATE THEREOF <i>June 9, 1957</i>	NAME OF CEMETERY OR CREMATORIAL <i>Hillside Cemetery</i>
24. REC'D BY REGISTRAR <i>John Van Beating</i>		REGISTRAR'S SIGNATURE <i>John Van Beating</i>	LOCATION (City, town, or county) <i>Fredrick Md</i>
DATE <i>June 27</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Byrd 500 S. P. Hill St.</i>	
		ADDRESS <i>F. Balto. 151 Md.</i>	

REKAU V. S.

JUN 12 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6108

Item 2 Filed 10-17-57

06105

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYEVILLE, MD</b>		c. LENGTH OF STAY IN lb <b>5 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. STREET ADDRESS <b>1110 BOSTON ROAD BALTIMORE, MD 21210</b>	
3. NAME OF DECEASED (Type or print) <b>AMELIA</b>		First <b>A</b>	Middle <b>ELIA</b>
4. DATE OF DEATH <b>JUNE 19 1957</b>		5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 22, 1880</b>	
9. AGE (In years lost birthday) <b>76 yrs</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
10c. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CONRAD KAHL</b>		14. MOTHER'S MAIDEN NAME <b>FREDERICKA KAUFMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-22-7793</b>	
17. INFORMANT <b>Frank L. Smith Jr.</b>		Address <b>Cockeysville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteria Occlusion Endic</b> <b>1458</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>6/17, 1957, Baltimore, MD</b>	
21. I certify that I attended the deceased from _____, 1957, to _____, 1957, that I last saw the deceased alive on _____, 1957, and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Harold F. Kies</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-22-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>Wil iam Cook, Inc., 1217 St. Paul Street</b>	
24a. REC'D BY REGISTRAR <b>11-24-57</b>		24b. REGISTRAR'S SIGNATURE <b>D. L. Smith</b>	

BUREAU V. S.  
RECEIVED  
MAY 9 1957

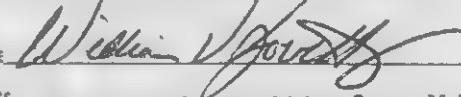
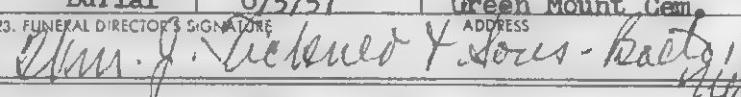
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

06106

Reg. Dist. No.

37

TO DEATH MEDICAL EXAMINER: This medical certificate should be exhumed within 24 hours after death. If any delay is necessary, please excuse the certificator, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar or removal.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Shawan</b>		c. LENGTH OF STAY IN 1b <b> </b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>3401 Greenway</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Bernice</b> Middle <b>T.W.</b> Last <b>Van Horn</b>		4. DATE OF DEATH June 2, 1957		Day 19 Month June Year 1957	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 7, 1903	
						9. AGE (in years last birthday) <b>54 yrs.</b>	
						IF UNDER 1 YEAR Months <b> </b> Days <b> </b>	
						IF UNDER 24 HRS. Hours <b> </b> Min. <b> </b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>			
11. BIRTHPLACE (State or foreign country) <b>Md.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>George W. Ward</b>				14. MOTHER'S MAIDEN NAME <b>Sally Thornton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b> </b>		16. SOCIAL SECURITY NO. <b> </b>		17. INFORMANT <b>Mr. Charles H. Buck - 215 E. Fayette St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive thoracic hemorrhage due to crushing</b> <b>injury of chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b> </b>		20f. (City or town) <b> </b>	
						(County) <b> </b>	
						(State) <b> </b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> . <b>William V. Lovitt, Jr., M.D.</b>							
ACTUAL SIGNATURE 				DATE SIGNED <b>6/3/57</b>			
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/5/57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Green Mount Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto. Md.</b>	
						(State) <b> </b>	
23. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS <b> </b>		24a. REC'D BY REGISTRAR DATE <b>6/6/57</b>	
						24b. REGISTRAR'S SIGNATURE 	

BUREAU V. A.

JUN 7 1957

RECEIVED

**DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHA3. Page 5 may be retained for your files. To be buried, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6110 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06107 /

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b <b>47 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2000 Mosby Ave.,</b>			d. STREET ADDRESS <b>2000 Mosby Ave.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>George Webster Vaughn</b>		First <b>George</b>	Middle <b>Webster</b>	Last <b>Vaughn</b>	4. DATE OF DEATH Month <b>June</b> Day <b>5</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 17, 1909</b>	9. AGE (in years last birthday) <b>47 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attendant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		
13. FATHER'S NAME <b>George W. Vaughn</b>			14. MOTHER'S MAIDEN NAME <b>Mamie Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Anna M. Vaughn 2000 Mosby Ave.,</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular disease</b> DUE TO (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
INTERVAL BETWEEN ONSET AND DEATH						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		DATE SIGNED				
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M. D</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-8-1957</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) <b>Woodlawn</b> (State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Howard Strong</i>		ADDRESS <i>309 W. North Ave.</i>		24a. REC'D BY REGISTRAR <i>Min 7</i>	24b. REGISTRAR'S SIGNATURE <i>Geo. S. M. Kieffer</i>	
VS. A15ME(5) SM 9/55						

RECEIVED  
BUREAU V. S.  
JUN 7 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06108

## 6111 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			b. COUNTY <b>Balto.</b>		
c. LENGTH OF STAY IN 1b <b>Catonsville</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b>			d. STREET ADDRESS <b>115 Symington Ave.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Santa</b>	Middle <b>Vazzana</b>	4. DATE OF DEATH <b>June 16 1957</b>	Month <b>June</b>	Day <b>16</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 21, 1871</b>	9. AGE (In years less birthday) <b>85 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>RET. SELF-EMP.</b>	11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>
13. FATHER'S NAME <b>KOSAKIS VAZZANA</b>			14. MOTHER'S MAIDEN NAME <b>FRANCUS DARRANCO</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>Mr. Harry Vazzana 115 Symington Ave.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>141X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Generalized Carcinomatosis</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <b>Carcinoma of Tongue</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cathedral Cem.</b>	20f. (City or town) (County) (State) <b>Baltimore Md.</b>
21. I certify that I attended the deceased from <b>4/12/61</b> , 1957, to <b>6/16/61</b> , 1957, that I last saw the deceased alive on <b>6/16/61</b> , 1957, and that death occurred at <b>10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2520 Eutaw Pl.</b> DATE SIGNED <b>6/16/61</b>					
ACTUAL SIGNATURE <b>I. S. ZINBERG M.D.</b>			M.D.		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>6-19-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Cathedral Cem.</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS Farley Funeral Home Catonsville Md.		
24a. REC'D BY REGISTRAR DATE JUN 20 57			24b. REGISTRAR'S SIGNATURE <b>Albrecht</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

JUN 20 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06109

## 6112 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>		b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>15 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nicholas</b>		First	Middle
			<b>Verdis</b>
4. DATE OF DEATH <b>June 4, 1957</b>		Month	Day
		Year	19
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Sebastian Verdis</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Ex. no. or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>220-03-5850</b>		17. INFORMANT <b>Sebastian Verdis, Reisterstown, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
145 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		<i>Carcinoma of Pharynx</i> 30 Months <i>Esophageal</i> 18 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. n. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10A M.</b>
20f. (City or town) <b>Reisterstown, Md.</b>		(County)	(State)
21. I certify that I attended the deceased from <b>1-1-</b> , 19 <b>54</b> , to <b>6-4-57</b> , that I last saw the deceased alive on <b>6-2-57</b> , 19 <b>57</b> , and that death occurred at <b>10A M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Reisterstown, Md.</b>	DATE SIGNED <b>8-4-57</b>
ACTUAL SIGNATURE <i>J. F. Eline</i>		PHYSICIAN'S NAME (Type) <b>Dr. G. S. Eline</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 10/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>All-Saints</b>
22d. LOCATION (City, town, or county) <b>Reisterstown, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>6-5-57</b>	24b. REGISTRAR'S SIGNATURE <b>Mary B. Sline</b>

RECEIVED  
BUREAU Y. S.  
JUN 7 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6113 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06110 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO.				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD			
				b. COUNTY BALTO			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLIVER BEACH				c. LENGTH OF STAY IN 1b			
				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLIVER BEACH			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ROUTE 14 BOX 228 BALTO 20				d. STREET ADDRESS ROUTE 14 BOX 228 BALTO 20			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First CLARENCE	M M	Middle WACHOB	Last	4. DATE OF DEATH JUNE 14	Month Year 1957
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 17-1894	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST				10b. KIND OF BUSINESS OR INDUSTRY MARTIN CO.		11. BIRTHPLACE (State or foreign country) PA	
13. FATHER'S NAME JOHN WACHOB				14. MOTHER'S MAIDEN NAME ELIZ. ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT GLADYS WACHOB Address SAME AS	
						Ave 45	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) immediate cause (a), stating the underlying cause last. DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None -			
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m.		19	20d. INJURY OCCURRED WHILE at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE M.B. Davis EXAMINER'S NAME (Type) M.B. DAVIS MD				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/17/57	22c. NAME OF CEMETERY OR CREMATORIUM EBENEZER		22d. LOCATION (City, town, or county) BALTO. CO. MD (State)		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Connolly Esse 21nd				ADDRESS	24a. REC'D. BY REGISTRAR JUN 18 1957	24b. REGISTRAR'S SIGNATURE which Burial	

BUREAU V. S.

JUN 18 1957

REGELIV E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6114

## CERTIFICATE OF DEATH

06111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Suitland, Maryland</b>		d. STREET ADDRESS <b>4622 Lacy Avenue</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Lena</b>	Middle <b>Katherine</b>	Last <b>Waidman</b>	4. DATE OF DEATH Month <b>June</b>	Day <b>7</b>	Year <b>19 57</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 1, 1884</b>	9. AGE (In years last birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	Days <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Christian Kieffeler</b>		14. MOTHER'S MAIDEN NAME <b>Carolyn</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  + + + + DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)  DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from <b>May 21</b> , 19 57 to <b>JUNE 7th</b> , 19 57, that I last saw the deceased alive on <b>JUNE 7th</b> , 19 57, and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>David Everett Edwards</b> PHYSICIAN'S NAME (Type) <b>DAVID EVERETT EDWARDS</b>						ADDRESS (Street, city or town, state) <b>SUITLAND, MARYLAND</b>		DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-11-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>SUITLAND, MARYLAND</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chamberlain Co. 517-11th St. S.E.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 12 57</b>		24b. REGISTRAR'S SIGNATURE <b>A. L. Schlesinger</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 10 1957

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06112/60

6115

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION High Hopes Farm Baldwin Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) Clarence Leroy Walter		d. STREET ADDRESS High Hopes Farm Baldwin Md.	
4. DATE OF DEATH June 20		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1901
9. AGE (in years lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supert. of Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Western Electric	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry J. Walter		14. MOTHER'S MAIDEN NAME Emma Peppler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 TO 4186	
17. INFORMANT Mamie T. Walter		Address High Hopes Farm Baldwin Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4.90.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/24, 1953 to 6/20, 1957, that I last saw the deceased alive on 19, and that death occurred at 1:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) CLIFFORD F. HUDSON, Fork, Md. DATE SIGNED 6/21/57	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		CLIFFORD F. HUDSON	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-22-1957	
22c. NAME OF CEMETERY OR CREMATORIAL Saint Johns Episcopal		22d. LOCATION (City, town, or county) Kingsville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lorraine Funeral Home		24a. REC'D BY REGISTRAR ADDRESS 7401 Belair Rd. DATE JUN 24 1957	
		24b. REGISTRAR'S SIGNATURE Dr. Peter L. Bennett	

RECEIVED

BUREAU V. A.

JUN 24 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06113

Reg. Dist. No.

6116

## CERTIFICATE OF DEATH

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	c. LENGTH OF STAY IN 1b <i>38 yrs</i>	b. COUNTY <i>Baltimore</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1501 Sudbrook Rd</i>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>John Odenheimer</i>		First <i>John</i>	Middle <i>Odenheimer</i>
4. DATE OF DEATH Month <i>June</i>	Day <i>13</i>	Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>13 Jan 1875</i>
9. AGE (In years last birthday) <i>82 yrs</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> Months <i>8</i>	11. IF UNDER 24 HRS <input type="checkbox"/> Days <i>0</i>	12. IF UNDER 24 HRS <input type="checkbox"/> Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Executive</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Roofing &amp; Sheet Metal</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>Charles A. White</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Fitzell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-03-4726</i>	
		17. INFORMANT <i>Mrs. Elsie White</i>	
		Address <i>50 Sudbrook Pikesville 8 Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>few years</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
p.m.		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>	
21. I certify that I attended the deceased from <i>1950</i> , 19 <i>57</i> , to <i>13 June</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>12 June</i> , 19 <i>57</i> , and that death occurred at <i>7:45 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul H Royse</i>		ADDRESS (Street, city or town, state) <i>808 Reisterstown Rd.</i>	
PHYSICIAN'S NAME (Type) <i>PAUL H ROYSE MD</i>		DATE SIGNED <i>13 June 57</i>	
22a. FUNERAL, CREMATION, REMOVAL (Specify) <i>Cremated June 15 1957</i>		22b. DATE THEREOF <i>June 15 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Towson Cemetery</i>		22d. LOCATION (City, town, or county) <i>Pikesville</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Powell</i>		ADDRESS <i>1501 Sudbrook Rd.</i>	
		24a. RECORD BY REGULAR BAR DATE <i>JUN 17 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>John J. Murphy</i>	

BUREAU V. S.

JUN 17 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06114  
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>BALTO</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>M.D.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TOWSON</i>		c. LENGTH OF STAY IN lb <i>8 WKS</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>381 Endowwood Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>GEROLYN</i>	Middle <i>R.</i>	Last <i>WHYE</i>
4. DATE OF DEATH	Month <i>6</i>	Day <i>23</i>	Year <i>1957</i>
5. SEX	6. COLOR OR RACE <i>F C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>APRIL 27, 1937</i>
9. AGE (In years last birthday) yrs. <i>2</i>	10. IF UNDER 1YEAR Months <i>2</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (State or foreign country) <i>M.D.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>LEON WILLIAMS</i>	14. MOTHER'S MAIDEN NAME <i>Gladys Whye</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>Gladys Whye - 381 Endowwood Lane, Towson, Md.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>475 X</i> DUE TO <i>G pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH <i>12 Hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Upper Respiratory Infection</i> DUE TO <i>24 Hrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>SPARKS, MD.</i>
20f. (City or town) <i>(County)</i> <i>(State)</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Charles F O'Donnell</i>	DATE SIGNED <i>6/26/57</i>		
EXAMINER'S NAME (Type) <i>Charles F O'Donnell</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>6/25/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>STEPHENSON</i>	22d. LOCATION (City, town, or county) <i>SPARKS, MD.</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Chapman Jr. - 1201 M. St. N.E., Washington, D.C.</i>	ADDRESS <i>1201 M. St. N.E., Washington, D.C.</i>	24a. REC'D BY REGISTRAR DATE <i>JUN 26 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>

1 DEFECTIVE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

10. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, and 4 and 5 with the removal.

BUREAU V. S.

JUN 5 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6118

## CERTIFICATE OF DEATH

06115

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 which is detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Citonsville</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>MAX</b>		4. DATE OF DEATH <b>June 14</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>baker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>bakery</b>	11. BIRTHPLACE (State or foreign country) <b>Austria</b>
13. FATHER'S NAME <b>Israel Wachner</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Berstein</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b>			
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b>			
DUE TO (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
450.0			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 5, 1957</b> , to <b>June 14, 1957</b> that I last saw the deceased alive on <b>June 14, 1957</b> , and that death occurred at <b>1:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) <b>Spring Grove State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		DATE SIGNED <b>6-14-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-16-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Anar Israel</b>	22d. LOCATION (City, town, or county) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc 2100 Catonsville Place</b>	ADDRESS <b>2100 Catonsville Place</b>	24a. REC'D BY REGISTRAR DATE <b>JUN 18 1957</b>	24b. REGISTRAR'S SIGNATURE <b>W. L. Finch</b>

RECEIVED  
BUREAU Y. S.  
JUN 18 19

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06116

6119

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Baltimore</i> MARYLAND		Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Villa Nova Baltimore</i>		<i>Baltimore 7 Villa Nova</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in Hospital, give street address)		e. STREET ADDRESS	
		<i>3613 Buckingham Road</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
<i>George</i>		<i>Howard</i>	<i>Wilkie</i>
4. DATE OF DEATH		Month	Day
		<i>June</i>	<i>13</i>
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
<i>M.</i>		<i>W.</i>	<i>Sept 28 1879</i>
9. AGE (in years at death)		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
<i>97 yrs.</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Enginer</i>		<i>Dairy Bus</i>	<i>Baltimore</i>
12. CITIZEN OF WHAT COUNTRY?		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Thomas Wilkie</i>		<i>Leonore Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
		<i>218-32-533</i>	<i>Mrs. Catherine Lessner</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE) (a)		<i>Carcinoma of Head of Pancreas</i>	
DUE TO		<i>1 yr.</i>	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
<i>None</i>		<i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>
<i>None</i>			
20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE		DATE SIGNED	
<i>D. E. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>Cremation</i>		<i>June 17 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
<i>London Park</i>		<i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Loring Byers 5005 Ph St Baltimore Md.</i>			
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
		DATE <i>6/18/57</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1-2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU Y. A

JUN 2 1957

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**CTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06117  
30

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6120 CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catoctinville</i>		c. LENGTH OF STAY IN 1B <i>12 yrs 200 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove State Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Maryland</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas David</i>		First <i>Thomas</i>	Middle <i>David</i>
4. DATE OF DEATH <i>Jul 24 1892</i>	Month <i>JUNE</i>	Day <i>8</i>	Year <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jul 24 1892</i>
9. AGE (In years last birthday) <i>84 yrs.</i>	10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>minister</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Thomas David Wilkie</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>220-01-6365</i>	17. INFORMANT <i>Records: Spring Grove State Hospital</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <i>cerebro-vascular accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>epilepsy</i> (c) <i>arteriosclerotic cardio-vascular disease</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>35x3</i>			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>injury occurred at 10:15 P.M., from the causes and on the date stated above.</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 11</i> , 1942, to <i>June 8</i> , 1951, that I last saw the deceased alive on <i>June 6th</i> , 1951, and that death occurred at <i>10:15 P.M.</i> , from the causes and on the date stated above. ACTUAL <i>Charles Ward</i> M.D. ADDRESS <i>35x3</i> DATE SIGNED <i>July 10th 1951</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-4-57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>W.F. Oliver</i>	22d. LOCATION (City, Town, or county) (State) <i>BALTIMORE MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Cook Inc.</i>	ADDRESS <i>1217 St. Paul St.</i>	24a. REC'D BY REGISTRAR DATE <i>6/10/57</i>	24b. REGISTRAR'S SIGNATURE <i>L. J. Hedrich</i>

BUREAU V. 8  
RECEIVED  
JULY 1 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6121

## CERTIFICATE OF DEATH

061183

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>BALT.</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills MD.</i>		c. LENGTH OF STAY IN 1b <i>RURAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore MD</i>		d. STREET ADDRESS <i>1526 N Smalwood St.</i>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training School</i>				d. STREET ADDRESS <i>1526 N Smalwood St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Rachel</i>		First <i>Rachel</i>	Middle <i>Ellen</i>	Lost <i>Williams</i>	4. DATE OF DEATH <i>6 17 1957</i>	Month <i>6</i>	Day <i>17</i>	Year <i>1957</i>					
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/10/54</i>	9. AGE (In years last birthday) <i>3 yrs.</i>	IF UNDER 1 YEAR Months <i>7</i>	IF UNDER 24 HS Days <i>7</i>	Hours <i>0</i>	Min <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Paul S. Williams</i>		14. MOTHER'S MAIDEN NAME <i>Eva E. Sloane Williams</i>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Rosewood Records</i>		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>154.4</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. { <i>b</i> ) DUE TO <i>Congenital heart disease</i> (c) DUE TO <i>Epilepsy</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>253.2</i>						INTERVAL BETWEEN ONSET AND DEATH <i>5 min -</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>253.2</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>While at work</i>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Rosewood State Training School</i>		20f. (City or town) <i>Rosewood</i>		(County) <i>St. Mary's Co.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>6-7 1957</i> , to <i>6-17 1957</i> , that I last saw the deceased alive on <i>6-17 1957</i> , and that death occurred at <i>9:00 PM</i> , from the causes and on the date stated above										ADDRESS (Street, city or town, state) <i>Rosewood State Training School</i>		DATE SIGNED <i>18 June 57</i>	
ACTUAL SIGNATURE <i>Harry G. Butler</i>		PHYSICIAN'S NAME (Type) <i>Harry G. Butler, M.D.</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>JUN 21 57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>BALTO. NAT'L.</i>		22d. LOCATION (City, town or county) <i>BALTIMORE, MD.</i>							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick L. Glavin</i>		ADDRESS <i>16071 Druid Hill Ave.</i>		24a. REC'D BY REGISTRAR <i>JUN 19 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Mary Glavin</i>							

BUREAU N.Y.

JUN 19 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6122

## CERTIFICATE OF DEATH

06119  
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY /	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>22 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>6917 German Hill Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JOSEPH</b>	Middle <b>DALTON</b>	Last <b>WIMMER</b>	4. DATE OF DEATH <b>June</b>	Month <b>19</b>	Day <b>19</b>	Year <b>57</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 30, 1927</b>	9. AGE (In years last birthday) <b>29</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Specialist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Metal Products</b>		11. BIRTHPLACE (State or foreign country) <b>Dayton, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Oscar Wimmer</b>		14. MOTHER'S MAIDEN NAME <b>Ruby Carr</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-22-2992</b>		17. INFORMANT <b>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Kidney</b>		DUE TO (b) <b>CHRONIC GLOMERULARNEPHRITIS</b>				10 YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May <b>28, 1957</b> to June <b>19, 1957</b> and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Irving Freeman</i> PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service</b> ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>6/19/57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>JUNE 21-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. G. Connally &amp; Sons, 418 Eastern Ave., Balto. Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>Sullivan</b>		24b. REGISTRAR'S SIGNATURE <i>Herbey</i>	
				DATE <b>JUN 21 1957</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED V. S.

JUN 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6123 CERTIFICATE OF DEATH

06120

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY		<i>Baltimore</i> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE <b>MARYLAND</b> b. COUNTY	
<i>CATONSVILLE</i>		<i>3 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		d. STREET ADDRESS	
<i>OAK Hill Home</i>		<i>566 Old Edmondson Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
<i>ANNA M. WINTERS</i>					Month Day Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS
<i>FEMALE</i>	<i>White</i>		<i>MARCH 7-1858</i>	<i>99</i> yrs	Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>HOUSEWIFE</i>				<i>BALTO. Md.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
<i>PENNINGTON</i>		<i>UNKNOWN</i>		<i>U.S.A.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address	
<i>No</i>		<i>-</i>		<i>MR. HARRY R. WINTERS</i> <i>143</i> <i>COLLINS Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		<i>INTERSCEROTIC C-U-D</i> <i>10 yrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter notes of injury in Part I or Part II of Item 18.) <i>Senile Agitated Psychosis 1 yr.</i>			
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
Hour a. m. p. m.	19	White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21. I certify that I attended the deceased from <i>7/16/47</i> , 19 <i>19</i> , to <i>6/23/57</i> , 19 <i>19</i> , that I last saw the deceased alive on <i>6/21/57</i> , 19 <i>19</i> , and that death occurred at <i>8130 P. M.</i> from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>P. Arthur Rosberg M.D.</i> ADDRESS (Street, city or town, state) <i>2436 Washington Blvd Balti-30th St. 6/21/57</i> DATE SIGNED					
PHYSICIAN'S NAME (Type) <i>C. ARTHUR ROSEBERG MD</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)	
<i>Burial</i>	<i>June 26, 1957</i>	<i>Old. BALTO. NATIONAL</i>	<i>BALTO. MARYLAND.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
<i>S. Truman Schatz</i>		<i>3512 Frederick Ave.</i>	<i>JUN 26 '57</i>	<i>Q.W. Finch</i>	

BUREAU V. S.

JUN 26 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6124

## CERTIFICATE OF DEATH

06121

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	c. LENGTH OF STAY IN 1b 32 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hospice	d. STREET ADDRESS 3137 Keswick Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Eleanor Regina Wolf	First	Middle	Last
4. DATE OF DEATH June 1 1957	Month	Day	Year
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-25-1880
9. AGE (In years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Matron		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Wolf		14. MOTHER'S MAIDEN NAME Frederica Hess	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 212-09-4438	
17. INFORMANT Admission Record		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 120 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 44		INTERVAL BETWEEN ONSET AND DEATH 1 MIN.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 31, 1957, to June 1, 1957, that I last saw the deceased alive on May 31, 1957, and that death occurred at 12:30 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE WILLIAM A. PILLSBURY M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY DATE SIGNED 6/1/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 4/57	22c. NAME OF CEMETERY OR CREMATORY New Cathedral	22d. LOCATION (City, town, or county) Frederick P. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Auster E. Kinahan - 3515 Pitons/Cine	ADDRESS	24a. REC'D. BY REGISTRAR DATE JUN 6 1957	24b. REGISTRAR'S SIGNATURE H. L. DeLoach

BUREAU V. S

JUN 6 1972

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6125

## CERTIFICATE OF DEATH

Reg. Dist. No.

06122 *4c*

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Baltimore</i>				a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>		c. LENGTH OF STAY IN 1b <i>17-4751</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baldwin</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Gora Kidder Wood</i>		First	Middle	Last	4. DATE OF DEATH <i>June 11 1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 22, 1862</i>	9. AGE (In years last birthday) <i>95 yrs</i>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months <i>3</i> Days <i>21</i> Hours <i>0</i> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		12 CITIZEN OF WHAT COUNTRY? <i>Genesee 911 USA</i>	
13. FATHER'S NAME <i>Willard Kidder</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Kendall</i>		Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>- - -</i>		17. INFORMANT <i>Mrs Marshall Turner Baldwin</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i> DUE TO <i>?</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 wks.</i>		(b) <i>Gen. Arteriosclerosis</i> DUE TO <i>?</i>		(c) <i>Senility</i> DUE TO <i>Aet. 95</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chr. Polyposis &amp; Colitis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March</i> , 19 <i>41</i> , to <i>6-11-1957</i> , that I last saw the deceased alive on <i>6-11-1957</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Robert H. Silver</i> PHYSICIAN'S NAME (Type) <i>R. H. Silver</i>				ADDRESS (Street, city or town, state) <i>3105 N. Charles St.</i> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>July 14, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Highland Lawn</i>	
22d. LOCATION (City, town, or county) <i>Terra Haute Ind.</i>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Martin Gravitz Jarrettville</i>		ADDRESS <i>1414 1/2 Highlawn Rd.,</i> Md.		24a. REC'D BY REGISTRAR <i>IN 14 1957</i> DATE <i>14 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>Dr. J. L. Hamby</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SEARCHED INDEXED  
SERIALIZED FILED

SEARCHED  
INDEXED

RECEIVED - POLICE DEPARTMENT  
LAW ENFORCEMENT  
DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
FBI - WASHINGTON D.C.  
JUN 14 1957

BUREAU V. 2

JUN 14 1957

RECEIVED

WILSON PARK

SEARCHED

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06123 Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <b>DUNDAIK</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE <b>MARYLAND</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		<i>DUNDAIK</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<i>517 MAIN STREET</i>		d. STREET ADDRESS		<i>517 MAIN STREET</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>JAMES</b>	Last <b>WORRELL</b>	4. DATE OF DEATH	Month <b>JUNE</b>	Day <b>16</b>	Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 9 1898</b>	9. AGE (In years less birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>5</b>	Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>PEUERA Copper CONWAY, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>HENRY WORRELL</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-10-4988</b>		17. INFORMANT <b>LEO/LA E. WORRELL - 517 Main St.</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V Disease</b>										
INTERVAL BETWEEN ONSET AND DEATH										
4-2-50 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)										
DUE TO										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetes Mellitus</b>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Injury</i>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>		
(State) <b>Md.</b>										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <i>M.B. Davis</i>		DATE SIGNED <i>6/17/57</i>								
EXAMINER'S NAME (Type) <i>M.B. Davis MD</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-19-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arbutus Memorial Pk.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHARLES R. LAW - 802 MADISON AVENUE</b>		ADDRESS <b>CHARLES R. LAW - 802 MADISON AVENUE</b>		24a. REGD. BY REGISTRAR <b>1</b>		24b. REGISTRAR'S SIGNATURE <b>1957</b>				

BUREAU V. S.

JUN 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116124  
38

6126

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8313 Loch Raven Blvd</b>		e. STREET ADDRESS <b>18313 Loch Raven Blvd</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Mrs. Amelia Rose Young</b>	Middle Lost	4. DATE OF DEATH Month <b>June</b> Day <b>27th</b> Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1879</b>
9. AGE (In years lost birthday) <b>75 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Belfort, New York</b>	
10c. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Violet</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Weaver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mrs. Norine Estes, 8313 Loch Raven Blvd.</b>	
17. INFORMANT Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>400-001</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Coronary Thrombosis</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <b>2:30 A.M.</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>4230 Loch Raven Blvd</b> DATE SIGNED <b>6/27/57</b>	
ACTUAL SIGNATURE <b>William H. Justing</b>		PHYSICIAN'S NAME (Type) <b>Dr. William H. Justing</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/29/57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Maryland Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 28 1957</b>	
		24b. REGISTRAR'S SIGNATURE <b>Nabel Gray</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
BUREAU V. S.

JUN 29 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6127

## CERTIFICATE OF DEATH

06125  
47

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

BALTIMORE

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

FORT HOWARD

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

VETERANS ADMINISTRATION HOSPITAL

c. LENGTH OF STAY IN 1b  
30 HOURS3. NAME OF  
DECEASED  
(Type or print)First  
JAMESMiddle  
PLast  
YOUNG4. DATE  
OF  
DEATH  
JUNEMonth  
/ /Day  
6  
Year  
19 57

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. MARRIED  NEVER MARRIED WIDOWED  DIVORCED 

8. DATE OF BIRTH

9-12-1900

9. AGE (In years  
last birthday)  
56 yrs.10. IF UNDER 1 YEAR  
Months DaysIF UNDER 24 HRS.  
Hours Min10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

CONSTRUCTION

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SAMUEL YOUNG

14. MOTHER'S MAIDEN NAME

HATTIE THOMAS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes or no; or unknown) If yes, give war or dates of service)

YES

WW-II

16. SOCIAL SECURITY NO.

218-05-1129

17. INFORMANT

CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY  
IMMEDIATE CAUSE (a)

ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

INTERVAL BETWEEN  
ONSET AND DEATH  
UNKNOWN

422.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  
Diabetes Mellitus19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m. 19  
p. m.20d. INJURY OCCURRED  
While Not while  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 5, 1957, 11 P.M. to June 6, 1957, 59 P.M. and observed death  
and that death occurred at 5:00 P.M. from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) DATE SIGNEDACTUAL  
SIGNATURE

Irving Freeman, M.D. Chief Medical Service

ADDRESS

6/7/57

22a. BURIAL  22b. DATE THEREOF  
REASON (Specify)  
Burial22c. NAME OF CEMETERY OR CREMATORIUM  
Hyco Baptist Cemetery22d. LOCATION (City, town, or county)  
Camden, S. Carolina

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS  
Charles R. Law Mortuary, 802 Madison Ave. Balto. Md.24a. REC'D BY REGISTRAR  
DATE 6/8/5724b. REGISTRAR'S SIGNATURE  
Dawson L. Farley

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 12 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5944 CERTIFICATE OF DEATH

06126

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The form requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>M.D.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK 22</b>		c. LENGTH OF STAY IN 1b <b>14 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>102 DELMAR AVE</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>	
3. NAME OF DECEASED (Type or print) <b>LOUISE</b>		First <b>VICTORIA</b>	Middle <b>ZEIGA FUSE</b>
4. DATE OF DEATH <b>JUNE 14</b>		Month <b>Month</b>	Day <b>Day</b>
5. SEX <b>Fem.</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>MAR 30, 1911</b>		9. AGE (In years last birthday) <b>46</b>	10. IF UNDER 1 YEAR Months <b>Yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EXAMINER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING, MFG</b>	11. BIRTHPLACE (State or foreign country) <b>WISCONSIN</b>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>CHARLES</b>		14. MOTHER'S MAIDEN NAME <b>ANN HEIM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>(?)</b>	17. INFORMANT <b>HAROLD ZEIGA FUSE — SAME</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO <b>① CA Lung, ② CA Cervix Uteri</b>		INTERVAL BETWEEN ONSET AND DEATH  <b>Unknown</b>	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO  Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>BALTO. CO. MD</b>
21. I certify that I attended the deceased from <b>August</b> , 19 <b>56</b> to <b>May 11</b> , 19 <b>57</b> that I last saw the deceased alive on <b>May 11</b> , 19 <b>57</b> , and that death occurred at <b>245 1/2 M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>John G. Green</b>		ADDRESS (Street, city or town, state) <b>ADDRESS</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>6/11/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/14/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>GARDENS OF FAITH</b>
22d. LOCATION (City, town, or county) <b>BALTO. CO. MD</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Banks Bradley, Dundalk 22 Md.</b>		24a. DIRECTOR REGISTRAR <b>JUN 14 1957</b>	24b. REGISTRAR'S SIGNATURE <b>John G. Green</b>
VS A15 (4) 15M 9/55			

BUREAU V.

JUN 14 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2,13,14 - Birth cert. B.C.H.D. 7-18-57 a.m.  
6128 CERTIFICATE OF DEATH

06127-3

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH COUNTY School Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rogers Rosewood Training School	d. STREET ADDRESS 211 S. Calhoun		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First John	Middle Zijac	4. DATE OF DEATH 6/7 Month 6/7 Day 19 Year 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/55	9. AGE (In years last birthday) 1yr yrs.	10. IF UNDER 1 YEAR Months 0 Days Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) University Hospital	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Deceased (Dmitro)			14. MOTHER'S MAIDEN NAME Deceased (Elva)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records	
Address Rosewood At The Rosewood School Owings Mills, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral pneumonitis</u>			INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) <u>Severe Hydrocephalus &amp; convulsions</u> (c) <u>Pylitis</u>			Congenital to Rosewood since adm.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Structure baby - always a feeding problem poor nutrition</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/1/57, 19, to 6/7/57, 19, that I last saw the deceased alive on 6/7/57, 19, and that death occurred at 5:55 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Viola B. Johns			ADDRESS (Street, city or town, state) M.D. Rosewood, Owings Mills, Md 9/8/57		
DATE SIGNED 9/8/57					
PHYSICIAN'S NAME (Type) Viola B. Johns, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-10-57		22c. NAME OF CEMETERY OR CREMATORIUM Mt. CARMEL	
22d. LOCATION (City, town, or county) AURORA W. Va.					
(State)					
23. FUNERAL DIRECTOR'S SIGNATURE Philip Coch 2716 E. Monument St.		ADDRESS		24a. REC'D BY REGISTRAR DATE 6/10/57	
				24b. REGISTRAR'S SIGNATURE Mary Eline	

**RECEIVED**

JUN 11 1957

**BUREAU V. S.**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be left filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6129

### CERTIFICATE OF DEATH

06128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nursing Co.</b>		d. STREET ADDRESS <b>805 N. Washington St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ANNA</b>	Middle <b>ZINGOR</b>	Last
4. DATE OF DEATH	Month <b>June</b>	Day <b>13</b>	Year <b>1957</b>
5. SEX	6. COLOR OR RACE <b>female white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1881</b>
9. AGE (In years lost birthday) <b>75 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>James Doubek</b>	14. MOTHER'S MAIDEN NAME <b>Josephine Benedict</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <b>Lillian Z. Gray, daughter, above</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hyperensive Arteriosclerotic cardio vascular Disease		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
(c) DUE TO			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6/12</b> , 19 <b>57</b> , to <b>6/13</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/13</b> , 19 <b>57</b> , and that death occurred at <b>9 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Wm. H. Kammerr J.</b> M.D. ADDRESS (Street, city or town, state) <b>6011 York Rd. Baltimore, Md.</b> DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/17/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Redeemer Cem.</b>
22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR <b>JUN 18 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Mabel Gray</b>
ADDRESS <b>2601-3-5 E. Madison St.</b>			

BUREAU V. S.

JUN 18 1957

RECEIVED